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ADDRESSING THE INFLUENCE OF LEADERSHIP INCIVILITY UPON EMPLOYEES: UNDERSTANDING INDIVIDUAL EXPERIENCES AND DEVELOPING ORGANISATIONAL INTERVENTIONS

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DOccPsych

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Abstract

This thesis explored the influence of leadership incivility upon employees, with the aim of understanding individual experiences and developing organisational interventions. The research was undertaken within an acute NHS Trust setting, where through the author's professional work, the issue of lack of confidence in dealing with uncivil leadership became apparent. Recent research has explored incivility within different workplaces, but studies within the clinical setting are limited, and incivility within the Allied Health Professionals (AHPs), including Physiotherapy, is a current literature gap. A qualitative exploration of uncivil leadership was undertaken within the NHS Trust, and template analysis used to analyse data from semi structured interviews (N=20) conducted within the Physiotherapy department. The findings were presented and discussed in relation to 6 key themes, of "*What it feels like to work with these leaders*", "*Hierarchy*", "*Why they behave that way*", "*Patient care*", "*Workplace culture and culture of leadership*" and "*Challenging the behaviours*" (study 1). These themes informed the basis and design of an organisational intervention to give AHPs increased confidence in managing situations with uncivil behaviour. The intervention examined different strategies and coping techniques, ranging from directly challenging the uncivil individual, to learning to live with the behaviour through various techniques. A quasi-experimental study (study 2) consisted of pre and post measurements among AHPs in the NHS Trust. Participants completed a survey prior to the intervention (T1) and then after the intervention workshop (T2), split into an experimental group (n=50) and a control group (n=23). Measures of confidence (self-efficacy), Resilience (CD-RISC) were analysed using two-way mixed ANOVA'S. Measures of confidence in having a challenging conversation across different groups in the workplace, and in two different situations were analysed with paired t-tests. The intervention was successful and levels of confidence and resilience in having a challenging conversation significantly increased after the intervention. The results also demonstrated a significant increase in the confidence of the participants in having challenging conversations, across the groups and within different situations, so when the uncivil behaviour was directed at themselves or their team. Overall, the research programme contributes an evidence base for interventions to develop confidence and resilience in challenging uncivil behaviour of those in senior leadership positions.

Table of Contents

Chapter 1: Introduction	1
1.1 Chapter overview	1
1.2 Background of incivility in society	1
1.3 Definitions of civility and incivility	3
1.4 Professional doctorate objectives	4
1.5 Research aims and contributions.....	4
Chapter 2: Literature Review	6
2.1 Chapter overview	6
2.2 Culture and incivility in the workplace.....	6
2.2.1 Different constructs of workplace aggression	7
2.2.2 Definition of incivility in the workplace.....	8
2.2.3 Behavioural markers of incivility	9
2.2.4 Frequency of Incivility in the Workplace.....	9
2.3 Why individuals engage in workplace incivility	11
2.3.1 Changes in the global business world	11
2.3.2 Stressful work environments	11
2.3.3 Power.....	12
2.3.4 Informal social power.....	12
2.3.5 Status Hierarchies and Power.....	13
2.3.6 Status inequalities	14
2.4 Organisational and individual consequences of incivility	15

2.4.1 Organisational consequences	15
2.4.2 Individual consequences of workplace incivility	16
2.4.3 Incivility and self-efficacy	17
2.4.4 Emotional reactions	17
2.4.5 Incivility and identity.....	18
2.4.6 Worry and rumination	19
2.4.7 Incivility and stress	19
2.4.8 Short-term and long-term effects of incivility.....	20
2.4.9 The Contagious and spiral effect of incivility in the workplace	21
2.5 Factors that can shape and mediate the experience of incivility.....	21
2.5.1 Individual level moderators on the impact of incivility	22
2.5.2 Individual differences and responses to incivility	22
2.5.3 Contextual, job-related and situational factors.....	24
2.6 Coping strategies	24
2.6.1 Problem-focused and emotion-focused coping strategies.....	24
2.6.2 Outcomes and effectiveness of different coping strategies	25
2.6.3 Frequency of coping strategies	26
2.6.4 Avoidance and confrontation as a coping strategy	26
2.7 Protective factors to reduce the effects of uncivil behaviours	28
2.7.1 Psychological Capital (PsyCap)	28
2.7.2 PsyCap in organisational development and learning	29
2.7.3 Resilience	30

2.8 The role of leadership and incivility	30
2.8.1 Uncivil behaviour from those in leadership roles	31
2.9 Incivility in the context of healthcare and the NHS	32
2.9.1 Organisational context.....	32
2.9.2 Incivility within healthcare – nursing.....	33
2.9.3 Incivility and bullying within Physiotherapy	34
2.9.4 Incivility within medical teams - communication	35
2.9.5 Medical consequences of incivility – patient error	36
2.10 Chapter summary and links to the next chapter.....	37
Chapter 3 Study 1 - Qualitative exploration of incivility and leadership using Template Analysis.....	38
3.1 Chapter overview	38
3.2 Rationale for the current study	38
3.3 Approach	39
3.3.1 Epistemological position of template analysis	39
3.3.2 Participants - sample and recruitment	41
3.3.3 Sample size	42
3.3.4 The organisation – an NHS Trust.....	42
3.3.5 Materials	42
3.3.6 Interviews.....	43
3.3.7 Audio Recording of the interviews.....	44
3.4 Procedure	44

3.5 Transcription.....	46
3.6 Data analysis.....	47
3.6.1 Developing the template.....	47
3.6.2 Initial coding Template Revisions 1-3	47
3.6.3 Scrutiny and reflexivity.....	48
3.6.4 Member checking	49
3.6.5 Iterative coding: Template revisions 3-5	50
3.6.6 Interpretation.....	50
3.7 Findings and discussion.....	51
3.8 What it feels like to work with these leaders	51
3.8.1 Impact of consultants' inconsistent behaviour	52
3.8.2 Stress and rumination working with them	53
3.8.3 Coping strategies.....	55
3.8.4 Avoidance	57
3.8.5 Frightened.....	58
3.8.6 Made me more reflective of own behaviour	59
3.8.7 Enjoyment working with some of the consultants	60
3.9 Theme Hierarchy	62
3.9.1 Hierarchy on a day to day basis	63
3.9.2 God like	64
3.9.3 Old school consultants	65
3.9.4 Power.....	67

3.10. Why they behave that way	69
3.10.1 Explain behaviour by various ways	69
3.10.2 Excuse behaviours as clinical expertise	73
3.10.3 Classic style consultant	74
3.10.4 Lack of governance	75
3.10.5 Stress.....	76
3.11 Patient care	77
3.11.1 Impact of the consultant on the ward	77
3.11.2 Role of mediator between consultant and patient.....	80
3.11.3 Patient care with examples of good consultants and leadership	82
3.11.4 Incivility when the physiotherapist is not present.....	83
3.12 Workplace culture and culture of leadership	84
3.12.1 Previous management culture and resulting strategies.....	84
3.12.2 Relationship between leadership and culture of the workplace	86
3.12.3 Leaders clinically good – yet not good at other leadership	87
3.12.4 Bullying	88
3.12.5 Teamwork	90
3.13 Chapter summary and links to the next chapter	90
Chapter 4 Study 1 B – Challenging and not challenging	93
4.1 Chapter overview	93
4.2 Challenging the behaviours.....	94
4.2.1 Feeling disrespectful to challenge.....	94

4.2.2 Not appropriate to challenge	95
4.2.3 Not challenge as just deal with it	96
4.2.4 Justification of the uncivil behaviour so not worth challenging	97
4.2.5 Not have the energy or skills to challenge	98
4.2.6 Challenging on behalf of their team and others	99
4.2.7 Challenging on behalf of consultant.....	102
4.2.8 Challenging on behalf of their profession and professional pride.....	102
4.2.9 Standing up to the leader – yet the behaviour stays the same or reverts back.....	104
4.2.10 Challenging the behaviour – positive results	106
4.2.11 Challenging in a jokey way – yet successful.....	106
4.2.12 How individual would like to challenge behaviour	107
4.2.13 Chapter summary and links to the next chapter	108
Chapter 5: Intervention Development.....	110
5.1 Chapter overview	110
5.2 Organisational interventions	110
5.3 Context of a clinical setting	111
5.4 Considering organisational sensitivities.....	113
5.5 Scoping meeting to design the intervention workshop	114
5.6 Importance of being evidence-based within healthcare	115
5.7 Workshop content selection	115
5.8 Harvard University’s conflict management training programme.....	117

5.9 Transfer of training	118
5.9.1 Individual factors.....	118
5.9.2 Training design factors	119
5.9.3 Work environment	119
5.10 Piloting the intervention - mechanism of change.....	120
5.11 Pilot workshop	121
5.12 The finalised workshop design.....	122
5.13 Intervention workshop content	123
5.14 Reflective evaluation of the workshop	124
5.15 Personal and work examples	126
5.16 Confidence in delivery	126
5.17 The timing of the workshop	127
5.18 Chapter summary and links to the next chapter	129
Chapter 6 – Intervention delivery and evaluation	130
6.1 Chapter overview	130
6.2 Study research questions.....	130
6.3 Intervention - to build confidence	131
6.4 Intervention to build resilience	132
6.5 Intervention to build confidence with different groups in the workplace...	133
6.6 Method.....	134
6.6.1 Participants and procedure:	134
6.6.2 Intervention design	135

6.7 Measures	136
6.8 Strategy of analysis	137
6.9 Results.....	138
6.9.1 Changes in confidence scores over time	138
6.9.2 Changes in resilience scores over time	139
6.9.3 Changes in self-reported confidence in managing challenging conversations with different groups.....	141
6.10 Discussion	144
6.11 Chapter summary and links to the next chapter	145
Chapter 7 Reflectivity – development and journey.....	146
7.1 Chapter overview	146
7.2 Professional Doctorate Aims.....	146
7.3 Reflexivity	147
7.4 Prior to the Professional Doctorate	149
7.4.1 Business background	149
7.4.2 Occupational Psychology	149
7.4.3 University NHS health contract	150
7.4.4 Physiotherapy 360 leadership and development coaching programme	151
7.5 During the professional doctorate	152
7.5.1 Resilience training and workshops.....	152
7.5.2 AHP leadership Masters degree	153

7.5.3 University lead on health	154
7.5.4 Value of research led teaching.....	154
7.5.5 Progression as an Occupational Psychologist.....	155
7.5.6 Reflection on own leadership style.....	155
7.5.7 External training and development – University wide.....	156
7.5.8 Training and development and reflection on my own personal development	156
7.5.9 External influences and reflection on the Intervention design	158
7.5.10 Reflection on the Professional Doctorate aims and objectives	159
7.6 Post doctorate	159
7.6.1 Career identity	160
7.7 Chapter summary and links to the next chapter	161
Chapter 8 – Discussion and conclusion	162
8.1 Chapter overview	162
8.2 Research questions.....	162
8.3 RQ1 Does uncivil leadership exist and to what extent is it part of the workplace culture?	163
8.3.1 Cultural justifications of uncivil behaviour	163
8.3.2. Consultants clinical and social skills	164
8.3.3 Changes in culture and incivility	165
8.4 RQ2 What effects does uncivil leadership have on the individual?	166
8.4.1 The effect of incivility on communication, consistency of behaviour and patient care	166

8.4.2 The effect of incivility on being more reflective	167
8.4.3 RQ1 and RQ2 summary	167
8.5 RQ3 What strategies do individuals utilise when experiencing such uncivil behaviour in the workplace?	168
8.5.1 Emotion focused coping strategies - justification and avoidance	168
8.5.2 Humour and team bonding.....	169
8.5.3 Needs of the patient	170
8.6. RQ4 Do individuals challenge uncivil behaviour and to what results?	171
8.6.1 Challenging seniority and when incivility directed to the individual or their team	171
8.6.2 Difference between confrontation and challenging and the impact of humour	172
8.6.3 Confronting and challenging the uncivil behaviour and subsequent results.....	173
8.6.4 The need for training and skills in challenging conversations	174
8.7 RQ5 How can individuals be more effective at challenging incivility?	174
8.7.1 Research questions and hypotheses	175
8.7.2 Confidence when challenging senior staff and consultants.....	176
8.8 Limitations of the research	177
8.8.1 Limitations with regards to the intervention delivery and evaluation .	178
8.9 Further studies	179
8.10 The doctorate programme aims	181
8.11 Chapter summary	182

APPENDICES	i
Appendix A: Study 1 - The interview schedule.....	ii
Appendix B: Study 1 - Participant consent form for recording interviews.....	iv
Appendix C: Study 1 - Participant information sheet.....	v
Appendix D: Study 1 - Participant consent form.....	viii
Appendix E: Study 1 - Participant debrief sheet.....	x
Appendix F: Pre-defined a-priori themes.....	xii
Appendix G: Template Analysis – Template 1	xiv
Appendix H: Changes from Template 2 to 3 and then 3 to 5.....	xviii
Appendix I: Template 5	xxix
Appendix J: Template 6	xxxii
Appendix K: Workshop materials.....	xxxiv
Appendix L: Study 2 – Participant information sheet	lv
Appendix: M Study 2 – Participant Consent form	lix
Appendix N: Study 2 - Participant debrief form	lx
Appendix O: Post workshop feedback.....	lxii
Appendix P: Study 2 survey.....	lxv
References	lxxiii

List of Tables

Table 6. 1 Descriptive statistics for confidence (self-efficacy) scores across group and time	138
Table 6. 2 Descriptive statistics for resilience scores across group and time	140
Table 6. 3 Difference in confidence in having challenging conversations at time 1 and time 2.	142

List of Figures

Figure 6. 1 Two-way interaction between time and group for confidence scores	139
Figure 6. 2 Two-way interaction between time and group for resilience scores	140

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Authors Declaration

I declare that the work contained in this thesis has not been submitted for any other award and that it is all my own work. I also confirm that this work fully acknowledges opinions, ideas and contributions from the work of others.

Any ethical clearance for the research presented in this thesis has been approved.

Approval has been sought and granted by the Faculty of Health & Life Sciences Ethics Committee on 25th April 2016, 19th November 2018 (amended 23 November 2018).

I declare that the word count of this thesis is 56,430 (including tables and quotations)

Name:.....

Signature:.....

Date:.....

Chapter 1: Introduction

1.1 Chapter overview

This chapter sets the wider applied context for this professional doctorate and the rationale for the study, by examining incivility in society and positioning this within the workplace. Chapter 2 outlines the theoretical and empirical basis for this applied research area, with a review of the current academic literature, as well as outlining gaps and areas for future study.

The author of this thesis is a Chartered Psychologist, with a background in corporate business and higher education. The research originates from a real-world issue that was encountered as part of the researcher's daily work, when delivering a programme of employee development workshops at an acute NHS Trust hospital. This led to the development of a discrete intervention that was delivered; this is evaluated in chapters 5 and 6. The research represents both the development of a project to address a real-world issue and also a period of professional progression and advance, described in chapter 7.

1.2 Background of incivility in society

Incivility is an affront to human dignity and an assault on a person's self-worth (Clark, 2017) and is certainly not a new concept, as derived from the Latin term *et non est civis*, meaning "not of a citizen". The first book in western literature devoted to the concern of such societal behaviour was in 1530, by the scholar Desiderius Erasmus of Rotterdam. He was so dismayed by the amount of ill-mannered people that he published a book titled "A handbook on good manners for children". He hoped if young children were trained in civility, they would then become civil adults (Merchant, 2008).

“Defer to each other with mutual respect. He who defers to his equal or inferior is not, by doing that, demeaning himself, but is more civil and therefore more worthy of respect. We should speak respectfully and succinctly to our superiors; lovingly and kindly to our contemporaries” (Merchant, 2008, p.67).

Carter (1998) in his book *“Civility: Manners, Morals and the Etiquette of Democracy”* discusses how the idea of needing more civility is no new thing. The term civility has been used throughout history; in modern England and western Europe, being civil indicated that your behaviour was of a proper conduct (Gillingham, 2002).

There are many studies discussing the overall decline of civility and these have particularly focused on American society, with the average American encountering incivility 6.7 times a week, with 75% commenting it had reached a crisis level (Kenski, Filer & Conway-Silva, 2018). Within the UK, the increase in incivility is prevalent in society from road rage, to desk rage or just general rudeness (Clark, 2017; Clark & Carnosso, 2008). By example, the severity of road rage has increased, as years ago it was expressed through honking horns or with hand gestures, whereas more recently physical and property damage are often being reported (Moller & Haustein, 2018).

Incivility has particularly been studied in the world of politics, and in the 2019 elections in the United States, Donald Trump openly used incivility as a key part of his campaign strategy, with citing blame and attacking those who challenged him. Despite this his behaviour was accepted. Although 72% of Americans considered his actions uncivil, 53% of that 72% said they still voted for him (Pew Research Center, 2016). In the UK the Policy Exchange (2018), a UK think tank wrote a report about the growing concerns of a new ethos of incivility in public life. They examined how political debate has recently coarsened, as identified by a new norm, seeing politicians demeaning the opposing view. A report was

commissioned by the Government Committee for Standards in Public Life, called “Intimidation in Public Life” (2017) after the Labour’s Chief whip complained about the momentum of abuse of MPs. The report summarised that the extent of intimidation in UK politics is so prevalent, that it poses a threat to the very nature of representative democracy. In response to the rise of incivility in public life, the Policy Exchange set up a Civility Hub, in late 2018 to track and analyse uncivil modes of politics, with the aim of creating the first comprehensive database of such material. They intend to produce a regular ‘civility’ index, to identify dominant themes and hotspots, that they see as poisoning political public life.

1.3 Definitions of civility and incivility

Despite the growing concern described above, there is a lack of agreement on definitions of civility and incivility. Carter (1998) describes civility as the sum of the many sacrifices that we need to make to live together, so a demonstration of respect. The key element of respect is noticeable across many definitions, as Clark and Carnosso (2008) state incivility creates an atmosphere of disrespect, conflict and stress, created from the disregard of others. Clark (2017) further defines incivility as an affront upon our self-respect and an assault on human dignity. Although, Roter (2019) suggests that the definition of what civility is today can be difficult, as cultures and countries become increasing multi-national, so can view what classifies as uncivil behaviour very differently. As workplaces do not operate in a vacuum, there is a clear link between increases in incivility in society and increases in incivility in the work environment (Porath & Pearson, 2010; Roter, 2019); this link therefore may reflect some of the contextual examples described above. The position of incivility within the workplace as a growing concern will be developed within the literature review in chapter 2.

This thesis examines incivility in the workplace with the objective of expanding knowledge of its occurrence, the effects it causes and how organisations might confront this as a problem. The current research needs to be undertaken within the considerations of the aims of the professional doctorate, as outlined below.

1.4 Professional doctorate objectives

The objectives of the professional doctorate in Occupational Psychology underlie this thesis and will be discussed in more detail at various points throughout its development. The doctorate programme provides an opportunity for practitioner Occupational Psychologists to further enhance their theoretical and applied understanding of Occupational Psychology, through the following aims:

- Developing Occupational Psychologists' ability to apply psychological theory to the real world, provide an evidence base for their practice, whilst also reflecting critically upon their own practice and application of psychology.
- Enabling students to identify innovative solutions to existing work-based problems and in turn make an original contribution to the field.

1.5 Research aims and contributions

The research programme will focus on the following research questions:

- Does uncivil leadership exist and to what extent is it part of the workplace culture?
- What effects does uncivil leadership have on the individual?
- What strategies do individuals utilise when experiencing such uncivil behaviour in the workplace?
- Do individuals challenge uncivil behaviour and to what results?
- How can individuals be more effective at challenging incivility?

The doctorate research programme makes the following contributions:

- A critical review of the current literature on incivility in the workplace, outlining current gaps and areas for future study, that will benefit future practice and enhance the theoretical understanding of this area of Occupational psychology (chapter 2).
- An in-depth qualitative examination of incivility experiences in the real world setting of an NHS Trust hospital. This allows the application of the theoretical evidence, through examining actual experiences described during interviews within a qualitative study, (chapter 3 and 4).
- A description of the development of an evidence-based intervention developed to challenge incivility that will benefit practice (chapter 5).
- The evaluation of an incivility intervention to enhance knowledge and increase confidence when confronting incivility in the workplace (chapter 6).
- A critical reflective development of the researcher's own practice and journey throughout this doctorate research programme (chapter 7).
- A concluding chapter of the thesis, summarising the findings from both studies by answering the research questions, as well as highlighting limitations and suggesting future research studies (chapter 8).

Chapter 2: Literature Review

2.1 Chapter overview

This chapter provides a review of literature examining the influence of leadership incivility upon employees, outlining individual experiences and the rationale for developing an organisational intervention. The review is structured as follows 1) Chapter overview 2) Culture and incivility in the workplace 3) Why individuals engage in workplace incivility 4) Organisational and individual consequences of incivility 5) Factors that can shape and mediate the experience of incivility 6) Coping strategies 7) Protective factors to reduce the effects of uncivil behaviours 8) The role of leadership 9) Incivility in the context of healthcare and the NHS and 10) Chapter summary. Limitations of the existing literature are discussed as a rationale for the studies of this thesis.

The rise and growing concern of incivility in society was discussed in the previous chapter, and this is constantly enacted through our interactions and behaviours in the workplace (Hofstede, Hofstede & Minkov, 2010; Schein, 1993). Such workplace culture will be examined in the section below.

2.2 Culture and incivility in the workplace

Culture in the workplace is seen as the way things are done (Hofstede et al., 2010; Schein, 1993) and incivility is closely related to this culture (Reichl, Leiter & Spinath, 2014; Salin, 2003; Salin 2015). The dominant culture of society is also linked to the acceptance and tolerance of workplace incivility (Lim & Lee, 2011; Loi, Loh & Hine, 2015; Power et al., 2013), as well as the culture of the industry in which they operate (Omari & Paull, 2013). Further examination of incivility within the workplace will be explored in the section below, first examining wider constructs of workplace aggression, and then incivility.

2.2.1 Different constructs of workplace aggression

Negative behaviours in the workplace denote a wide range of ill treatments, and consist of constructs such as, bullying, harassment, incivility, abusive management and unfair or unreasonable practices (Hodgins & McNamara, 2014). Hershcovis (2011) highlights the abundance of overlapping constructs of workplace aggression that have rapidly grown in the past 20 years, and although researchers have conceptually distinguished these different constructs, it is unclear whether this proliferation is useful or becoming a constraint. Although it is essential to distinguish workplace incivility from other aggressive constructs, such as bullying, it is confusing that incivility can still share some features with these constructs, but in their milder forms (Martin & Hine, 2005).

To distinguish constructs of workplace aggression, a concept analysis of 50 studies was undertaken to examine incivility in the workplace. The defining attributes of incivility were summarised as ambiguous intent, violation of mutual respect, low intensity and lack of physical assault (Abolfazl Vagharseyyedin, 2015). Differences of the constructs become apparent when incivility is compared with the definition of bullying, from the Advisory, Conciliation and Arbitration Service (ACAS), often used by organisations (Illing et al., 2016). With bullying, ACAS emphasise behaviours such as being offensive, intimidating and malicious, with an abuse or misuse of power. This results in the recipient being undermined, humiliated, denigrated or injured. In contrast to definitions of incivility, bullying is a process that escalates, has persistence, duration and an imbalance of power (Einarsen & Nielsen, 2015). Roter (2019) classifies the myriad of behaviours that occur in the workplace into three categories, non-deviant, dysfunctional and deviant. Non-deviant are passive behaviours that are referred to as uncivil, and examples include rolling eyes or ignoring someone. The perpetrators may not be

aware how such behaviours can affect someone in a negative way, and they may, or may not, be intentional. Dysfunctional behaviour is repetitive and causes intentional harm to the individual such as, constant humiliation of the same person in front of others. In these circumstances the person is mostly aware of what they are doing, and their behaviours. The third level is deviant behaviours that are extreme and intentionally damage the organisation and the employees. These behaviours can be harmful to security, safety and even life (Paetzold, O'Leary-Kelly & Griffin, 2007).

2.2.2 Definition of incivility in the workplace

The distinguishing and definitional elements of incivility from the other constructs of workplace aggression are therefore based on several dimensions. The first is that uncivil behaviour is low intensity. Most other workplace constructs are not defined in terms of their intensity, but more inferred, such as with bullying that has a higher intensity, due to its persistence and frequency (Hershcovis, 2011). The second differentiating feature is that there is an ambiguous intent to harm (Andersson & Pearson, 1999), although this notion of intent is often debated (Hershcovis, 2011). These two elements differentiate it from other negative workplace phenomena including workplace aggression, emotional abuse, bullying and social undermining. The latter constructs are more overt, and the targets of these behaviours would be very likely to interpret them as intentional (Andersson & Pearson, 1999; Schilpzand, De Pater & Erez, 2016). A key aspect of the definition of incivility is that it is subjective, so it does not matter if the individual was actually treated insensitively, but ultimately whether they felt disrespected (Porath, 2016). Uncivil behaviour is in the perception of the receiver not the sender, as the person interpreting it could also be a bystander or a witness, rather than experiencing it themselves (Barash, 2004). Incivility can take subtle forms and is

often started by thoughtlessness, rather than actual malice. As such, behaviours are less obvious and they become easier to overlook than overt bullying (Porath & Pearson, 2013).

In consideration of the discussion and literature review above, this study will use the original definition of workplace incivility, as it contains all the key aspects. Incivility is therefore defined within this thesis, as “low-intensity deviant behaviour with ambiguous intent to harm the target, in violation of workplace norms for mutual respect” (Andersson & Pearson, 1999, p.457).

2.2.3 Behavioural markers of incivility

Incivility is wide ranging with many examples of behaviour that include not listening, making demeaning remarks and talking down to others (Pearson & Porath, 2010) sarcasm, disparaging remarks and being ignored (Lim, Cortina & Magley, 2008). The most common types of rude behaviour according to Johnson and Indvik (2001) include, condescending comments, overruling a decision without a reason, disruption in meetings, reprimands in public, talking behind someone's back, ignoring people, not giving due credit to someone, giving negative eye contact or insulting or shouting at others.

Overall, the above behaviours are summarised as being uncivil, as they are notable for their rudeness and general lack of courtesy for others (Andersson & Pearson, 1999; Giumetti et al., 2013; Pearson, Andersson & Porath, 2000; Porath & Pearson, 2013; Welbourne & Sariol, 2017).

2.2.4 Frequency of Incivility in the Workplace

When surveyed, most employees have witnessed more than one act of incivility at their workplace (Pearson et al., 2000). The frequency of incivility in the workplace identifies growth; in 2005, 50% of individuals had experienced incivility at least

once a week but ten years later, this figure had risen to 62% at least once a week (Porath, 2016; Porath & Pearson, 2010;). Recent diary research has demonstrated that this figure could be even higher, with 50% of employees experiencing incivility on a daily basis, when examining incivility with this type of methodology (Nicholson & Griffin, 2015).

Pope and Burnes (2013) name this persistent negative workplace behaviour as the elephant in the room, with Leiter (2013) seeing it as a contemporary workplace crisis, with levels of incivility becoming a priority of major proportions. The Chartered Institute of Personnel and Development (CIPD, 2015) undertook a survey of UK employees, and found that four in ten employees had experienced some form of workplace conflict in the last year, either an isolated dispute or an ongoing difficult relationship. The person an employee would most commonly have experienced conflict with, was their line manager or colleagues; in effect, people that cannot be easily avoided in the workplace.

A similar increase has been apparent in academic research, even though incivility has only been an area of research for the past two decades (Schilpzand et al., 2016). The term incivility has experienced a rapid growth, with a current average of one article published per day (Cortina, Kabat-Farr, Magley & Nelson, 2017). Most of the body of academic work stems from a seminal paper by Porath and Pearson (2010) when they first introduced incivility from a social interactionist perspective, positioning it as an interactionist event (see for example Miner, Settles, Pratt-Hyatt & Brady, 2018; Schilpzand et al., 2016). Their research into workplace behaviour became the foundations for this new area of academic study.

2.3 Why individuals engage in workplace incivility

2.3.1 Changes in the global business world

Changing social and economic developments have given rise to a leaner global business world, producing more stress through challenging work environment processes such as downsizing, restructuring or organisational changes (Salin, 2003). Uncivil behaviours frequently change based on levels of stress, cultural turbulence, uncertainty and complexity as well as the volitional nature of workplaces (Porath, 2016).

A sector where a changing economic context is particularly noticeable is academia, where incivility and workplace mistreatment has grown rapidly (Rawlins, 2017). The reasons are attributed to the external environment changing faster than the academic culture and organisational governance can accommodate, so producing negative workplace repercussions (Rowland, 2009). For example, the rate and subsequent costs of workplace incivility has resulted in American universities openly developing civility campaigns, for instance in Oregon State University, Central Florida University and the State University of New York (Schilpzand et al., 2016).

2.3.2 Stressful work environments

Within stressful working environments, the occurrence of incivility will increase, as individuals with higher stress levels display more incivility than those with lower levels (Roberts, Scherer & Bowyer, 2011; Santos, Barros & Carolino, 2010). When individuals try and make sense of an uncivil act of behaviour, they often attribute some of the blame to the situation, such as, excusing the rudeness due to stress; such techniques may reduce the negative consequences associated with the uncivil behaviour (Shaw, Wild, & Colquitt, 2003). The majority of people say they

are overloaded, stressed and have no time to be nice at work (Pearson & Porath, 2005), and incivility may have increased with such work-based relationships changing (Porath & Pearson, 2010). Further, the increased use of electronic communication, such as email, has resulted in a depersonalisation of communication, making incivility easier to display within a stressful environment (Pearson & Porath, 2009).

2.3.3 Power

The demonstration of power is seen as one of the most frequent reasons for uncivil behaviour. Given that power structures and power imbalances are always present in the workplace, an uncivil work environment is unavoidable (Klingberg et al., 2018). Incivility is inherently a political behaviour and frequently enacted by the more powerful towards those with less power (Cortina & Magley, 2009) resulting in acts of uncivil behaviour in the workplace, that demonstrates autonomy and control (Homan, Van Kleef & Sanchez-Burks, 2016). The mere act of incivility is an expression of power, and the powerful will be motivated to maintain their status (Willis & Guinote, 2011), as they are goal-directed, and quite often, that goal is simply the pursuit and preservation of power (Salin, 2003).

2.3.4 Informal social power

Incivility can represent a challenge on an individual's status and communicate to others that the target is not valued (Porath & Pearson, 2009) with differences in power operating both on a formal structured basis as well as an informal basis. Informal power is created through situational and contextual characteristics, such as a minority status or gender roles, and seen as a way of asserting social power (Raven & French, 1958). The demonstration of power based on gender or position, plays a role in experiences of incivility, as those with less social power are at higher risk of being mistreated. For instance, more women than men report uncivil

experiences in male-dominated professions, such as the law (Cortina, Magley, Williams & Langhout, 2001). In a study of a federal court system, approximately one third of the acts of incivility reported, were instigated by individuals who had powerful positions in the organisation. These often became habitual, as those with less hierarchical power were unable to resolve the behaviour and challenge it, without a detrimental impact on their career (Cortina et al., 2001).

A focus on power is apparent in the term selective incivility, where uncivil behaviour can be attributed to forms of discrimination, such as gender and race (Cortina, 2008). Uncivil behaviours can also become so subtle and ambiguous, that they are misinterpreted by others as being discourteous, yet evolve out of discriminatory behaviour, rather than formal power differences in the workplace (Kabat-Farr, Cortina & Marchiondo, 2018).

2.3.5 Status Hierarchies and Power

People are attuned to their social status and accurate at identifying their place in the pecking order, through status hierarchies (Anderson, Srivastava, Beer, Spataro & Chatman, 2006). The powerful seek to maintain hierarchies, to preserve their power particularly to those who act as rivals in the workplace (Kennedy, Anderson & Moore, 2013). Being uncivil toward others can be used to signal power, and uncivil acts, even as minor as an eye roll can be interpreted as a status challenge (Porath, Foulk & Erez, 2015). The powerful tend to be competitive so can respond aggressively to those who might challenge them (Georgesens & Harris, 1998) and will defend those systems, such as hierarchies that provide them with power (Magee, Galinsky & Gruenfeld, 2007).

These status hierarchies serve an important function by creating an orderly division of influence among group members, allowing or denying individuals to perform certain behaviours (Bales, 1950; Berger, Rosenholtz, & Zelditch, 1980). High

status individuals control the group interactions and make decisions, whereas low-status individuals are expected to defer to others, speak less in interactions and not share their opinions as much (Berger et al., 1980; Goffman, 1972; Keltner, Hardiker & Staniland, 2003). To succeed as a group, some individuals must be motivated to act selflessly, undertake personal sacrifice and behave in ways that benefit the collective (Anderson et al., 2006).

2.3.6 Status inequalities

Status inequalities are reinforced by the way targets tend to respond to uncivil acts and behaviours. When an individual's status is challenged in the workplace, they are likely to base their responses on the perceived legitimacy of the person who was uncivil to them, as well as the consequences if they resist or challenge the behaviour (Porath, Overbeck & Pearson, 2008). Lower status employees try to maintain their professional demeanour and pay deference to the higher status individual, known as strategic deference (Lively, 2000). The term strategic implies that being submissive and absorbing such uncivil behaviour, may be the most effective option to minimise cost and maximise benefit. Furthermore, a status challenge from a lower status colleague will often produce a hostile response, if the individual believes the challenger does not have a legitimate claim to a high status (Porath, 2017; Porath et al., 2008).

Those of a lower status will often accept the uncivil behaviour using tactics, such as avoidance or conflict defusing behaviours (Porath et al., 2008) but such tactics mean that repeated acts of incivility form an accepted social norm. This makes the hierarchy more stable and more self-perpetuating (Anderson et al., 2006; Foschi & Lapointe, 2002), which in turn creates more structural inferiority (Lively, 2000). Behaving as though nothing has happened leaves no opportunity for the organisation or challenger to be aware of their offensive behaviour, which may also

explain why many organisations often seem to ignore incivility, concluding it is not a problem in their organisation (Pearson & Porath, 2005).

Recent research has highlighted how those of power are more likely to intervene when they witness workplace incivility, for instance by punishing the perpetrator and allocating them unpleasant tasks. Individuals with high power are also more likely than those with low power to confront a perpetrator, whereas, those with low power are more likely to avoid the perpetrator and support the target, as acts of incivility are seen as a status challenge to the powerful, and the hierarchy (Reich & Hershcovis, 2015).

2.4 Organisational and individual consequences of incivility

2.4.1 Organisational consequences

Although uncivil behaviours are often described as mundane or subtle, and subsequently often dismissed as not overtly harmful, the effects are far from mundane (Cortina & Magley, 2009; Cortina et al., 2017). Such uncivil behaviours can produce adverse collective consequences, and on an organisational level can have financial implications. These stem from costs of employee discontentment, leading potentially to job accidents, sick leave, team conflicts, a decline in productivity and increased turnover (Cortina, 2008). The monetary cost of incivility in the United States is estimated at \$14,000 per employee annually, due to project delays and cognitive distraction from work (Porath & Pearson, 2010). People are less likely to buy from a company they see as rude, and this can be either when the behaviour is directed at them, or another member of staff. Incivility is expensive and few organisations act to address it, as most managers agree that whilst incivility is wrong, few see the tangible costs it has on their organisation (Porath & Pearson, 2013).

2.4.2 Individual consequences of workplace incivility

Workplace incivility is also related to negative outcomes for the target individuals and leads to a wide array of consequences (Cortina et al., 2017; Kim et al., 2017) as well as negative emotions that may then affect individuals' functioning and performance in numerous ways (Mao, Chang, Johnson & Sun, 2019; Judge, Thoresen, Bono & Patton, 2001). These include lower job satisfaction (Penney & Spector, 2002) lower satisfaction with co-workers and supervisors (Martin & Hine, 2005) and reduced creativity, helpfulness and task performance (Pearson & Porath, 2005; Porath & Erez, 2007).

Other outcomes are symptoms of psychological distress increasing with higher disengagement and work withdrawal (Pearson, Andersson, & Wegner, 2001), higher levels of emotional exhaustion (Connolly, 2017) and an increased desire to leave the job altogether (Cortina et al., 2001; Hershcovis, 2011). Incivility is associated with target feelings of isolation and embarrassment, that in turn relates to targets' perceived job insecurity (Hershcovis, Ogunfowora, Reich & Christie, 2017). Other studies have identified how incivility can impair both task performance and engagement by disrupting cognitive processes, such as the memory (Cortina et al., 2001). Both one-time incidents and repeated occurrences of rudeness, can affect individual objective cognitive functioning, on routine as well as creative tasks (Porath & Erez, 2007).

Individual's work performance, effort and quality intentionally dropped by 40% to 50% after an uncivil act of behaviour (Porath & Pearson, 2013). Experiencing incivility can threaten an individual's sense of value to the organisation, particularly because the intent behind incivility is often unclear (Hershcovis et al., 2017). Witnesses of incivility can also be affected by this uncivil behaviour, as well as

those who are directly targeted, such as being less helpful and suffering from reduced task and creative performance (Cortina et al., 2017; Porath & Erez, 2007).

2.4.3 Incivility and self-efficacy

The target of uncivil behaviour is associated with lessened well-being (Martin & Hine, 2005) as recent studies found that workplace incivility plays a key role in lowering self-efficacy, and ultimately the employee's intention to leave the organisation (Riadi, Hendryadi & Tricahyadinata, 2019). Self-efficacy consists of an individual's belief of their capability to demonstrate effective performance, as according to the social cognitive theory (Bandura, 1997) individuals develop beliefs by their perception. Therefore, an act of uncivil behaviour may be seen as a violation of the individual's standards of respect, and so decrease their individual self-efficacy (Cortina et al., 2017).

2.4.4 Emotional reactions

With stressors such as incivility, emotional reactions are especially pronounced for the most committed employees, identifying those individuals whom organisations value the most, will be the ones most harmed (Cortina et al., 2001). The ambiguity surrounding incivility can lead to inward focused emotions and feelings of guilt, as individuals try to assign meanings, often questioning their contribution and culpability to the behaviour. This can lead to guilt, potentially undermining confidence and self-worth (Silfver-Kuhalampi, Figueiredo, Sorthaix & Fontaine, 2015). Following uncivil behaviours towards them, targets use words such as, feeling down, disappointed, depressed and hurt (Pearson et al., 2001). Negative affect and guilt were also found in response to incivility, that linked to decreased empowerment, self-esteem and increased withdrawal (Kabat-Farr et al., 2018). An outward focused incivility driven anger is synonymous with an external locus of control, blaming others for a stressful situation (Smith, Haynes, Lazarus & Pope,

1993). This is similar to the incivility spiral model where workplace incivility can spiral with an act of reciprocation, eventually permeating an organisation (Andersson & Pearson, 1999).

2.4.5 Incivility and identity

The risk management model of workplace mistreatment considers why incivility matters, from a position of challenging individuals' identity. It starts from the basic premise that people are both delightful and dangerous (Leiter, 2013) and the model proposes that we constantly monitor these potential risks in our social environment. The model has three propositions, first, people want to belong, secondly, people notice how incivility impacts social standing, and thirdly workplace climates are self-perpetuating through reciprocity and emotional contagion. The model examines how the impact of incivility stems from its challenge to individual identity, defined through work roles and any personal relationships at work. These combine to contribute to the way individuals perceive themselves and others perceive them. The second way is through Social Identity theory (Ashforth & Mael, 1989; Burford, 2012; Tajfel & Turner, 2004) that examines the processes of how individuals define their identity in the workplace. This is achieved by developing a sense of membership of belonging to particular groups, through processes such as socialisation (de Swardt, van Rensburg & Oostuizen, 2017) and professional identity within the workplace (Weaver, Peters, Koch & Wilson, 2011). The risk management model proposes that incivility presents a social identity threat, as interactions in the workplace either confirm or challenge an individual's social identity. Incivility challenges the targets' identity and their status, for instance ignoring someone implies that you are not sufficiently important to warrant their time and attention (Leiter, 2013).

2.4.6 Worry and rumination

Research conducted in 17 industries showed that 80% of incivility victims lost time at work worrying about the incident. They felt their commitment to the organisation declined, as they replayed the act, thinking about the consequences of various responses (Porath et al., 2008). Such negative workplace rumination, or self-focused thinking, involves abstract and passive negative thoughts (Niven, Sprigg, Armitage & Satchwell, 2013). It can be associated with both active cognition preoccupation trying to solve a problem that has already occurred, or in anticipating a future work problem (Demsky, Fritz, Hammer & Black, 2019). Rumination is frequently associated with uncivil behaviour (Pearson et al., 2001; Porath et al., 2008) but the focus of incivility rumination is mostly around the distress after an uncivil event (Park, Fritz & Jex, 2018) or the subsequent recovery, such as psychological detachment from work and relaxation during non-work times, rather than anticipating uncivil behaviour (Demsky et al., 2019; Judge & Ilies, 2004). Within the literature examining workplace violence, individuals with a higher tendency to ruminate had a stronger negative relationship between exposure to violence, poor health and well-being, compared to those with a lower tendency to ruminate (Niven et al., 2013).

2.4.7 Incivility and stress

Being victimised by incivility results in stress for the target of the behaviour (Penney & Spector, 2005) and workplace incivility is a prevalent low-intensity stressor that can harm employees' psychological and physical well-being (Cortina et al., 2001; Porath & Pearson, 2013; Schilpzand et al., 2016). Workplace incivility can result in psychological distress, as resources, such as social support decline, and simultaneously demands at work, such as interpersonal conflict rise (Giumetti et al., 2013; Hobfoll, 1989). Incivility is considered a type of daily hassle and

interpersonal work stressor (Lim et al., 2008; Penney & Spector, 2005), and further stress may be caused as the target has doubts whether the rude behaviour was intentional. Such ambiguity can cause additional stress (Vahle-Hinz, Baethge & Van Dick, 2019), as intent to harm may be evident to the investigator of the incivility behaviour, but unclear to the target (Orobio de Castro, Veerman, Koops, Bosch & Monshouwer, 2002).

2.4.8 Short-term and long-term effects of incivility

Nicholson and Griffin (2015) emphasise how little attention has been paid to the short term effects of incivility, compared to the longer term effects such as, lowered job satisfaction, well-being and turnover, where such intentions are reasonably well established (Cortina et al., 2001; Johnson & Indvik, 2001; Pearson & Porath, 2005). Furthermore, exactly how these uncivil acts are then transferred into ill-effects, is not well understood, as little attention has been paid to the actual processes involved in the within-person, day-to-day management of work and home (Cortina et al., 2017; Van Hooff, Geurts, Kompier & Taris, 2006).

Edwards and Rothbard (1999) use affective spillover theory to propose how the negative effect of incivility may also impact feelings later in the day, and the next morning (Dudenhoffer & Dormann, 2013; Wang et al., 2013). Different sources of incivility are related to this end of workday negative effect (Adams & Webster, 2013). For instance, co-worker incivility was not related to next morning negative affect, because an alternative reason for the behaviour was imagined, whereas customer incivility continued to the next morning (Tremmel & Sonnentag, 2018).

Research into workplace incivility over time has mainly been cross sectional, identifying how incivility can increase negative affect, sometimes within seconds (Gabriel & Diefendorff, 2015) as well as the negative affect at the end of the working day (Zhan, Wang & Shi, 2016; Zhou, Yan, Che & Meier, 2015). There is

limited knowledge whether the detrimental effects of incivility are cumulative and how this impacts wellbeing and organisational commitment (Connolly, 2017).

2.4.9 The Contagious and spiral effect of incivility in the workplace

Not only do uncivil behaviours have detrimental effects on individual's well-being (Hershcovis, 2011) but can influence subsequent behaviours in the workplace, such as, counterproductive work behaviours (Penney & Spector, 2005) and lower organisational citizenship behaviour (Taylor, Bedeian, & Kluemper, 2012). The experience of incivility can also develop into more severe forms of workplace aggression through the incivility spiral (Andersson & Pearson, 1999). When uncivil behaviour is not addressed then it becomes normalised, as civil or uncivil behaviour is learnt and reinforced through repetition (Altmiller, 2016). This can ultimately lead to overtly aggressive behaviours with incivility spiralling between the parties, increasing the desire to reciprocate or retaliate. By identifying and addressing the smaller acts of incivility, this escalation into aggression and potentially violence in the workplace can be prevented (Clark, 2017). More recent studies have demonstrated that such reciprocation from incivility may go beyond the target and perpetrator, with consequences rapidly permeating the entire organisation (Cortina et al., 2017). For instance, Porath and Erez (2007) found that after exposure to incivility, individuals became less prone to help others and Foulk, Erez and Woolum (2016) conducted multiple experimental studies, showing how experiencing rude behaviour and incivility is contagious, like a common cold spreading through the organisation (Torkelson, Holm, Backstrom & Schad, 2016).

2.5 Factors that can shape and mediate the experience of incivility

Having reviewed the antecedents of incivility and the multi-level consequences experienced by individuals and organisations, the range of factors that can shape the experience of incivility are considered. A number of factors have been identified

that mediate the impact of incivility and its subsequent consequences, such as individual differences, selective incivility directed to stigmatised identities and job-related and situational factors (Cortina et al., 2017).

2.5.1 Individual level moderators on the impact of incivility

Individual differences play a role in how employees perceive and cope with incivilities, as some individuals are more prone to perceiving and experiencing incivility than others (Cortina et al., 2017). For instance, employees who are rated as high in neuroticism and low in agreeableness experience more incivility (Milam, Spitzmueller & Penney, 2009), as they are more sensitive to uncivil behaviour. Certain individuals who have a higher sensitivity to interpersonal treatments, experience stronger reactions to an uncivil act or behaviour (Bunk & Magley, 2011). Furthermore, individuals who are higher in trait anger, consciousness and positive affect will perceive unambiguous behaviours as uncivil, whereas those higher in openness are less likely to perceive them as such (Sliter, Sliter, Withrow & Jex, 2012).

2.5.2 Individual differences and responses to incivility

Individual differences may also determine how individuals respond to uncivil behaviour, as those with an external locus of control, low emotional stability, or perceptions that others have hostile intentions, may mean that uncivil behaviour will increase their end-of-day negative affect (Zhou et al., 2015). Those individuals who present as high in neuroticism also appear more likely to respond to uncivil behaviour by either ignoring and or avoiding the perpetrator (Beattie & Griffin, 2014).

The majority of previous research in understanding the causes and effects of incivility, such as, Lim et al., (2008) and Cortina et al., (2017) have focused on

generalised incivility (Gabriel, Butts, Yuan, Rosen & Sliter, 2018) and do not consider any subgroups, such as gender. Women experience higher incivility from co-workers and supervisors than their male co-workers (Cortina et al., 2001), and Cortina (2008) later introduced the theory of selective incivility, (see section 2.3.4), as a form of modern discrimination. This is when certain identities or groups of people are stigmatised, through conscious or unconscious selective uncivil behaviour. For instance, women are more likely to experience incivility as members of the less dominant group in the workplace (Cortina, 2008). However, it is unclear whether women are treated uncivilly by men, as members of the socially dominant group, or by other women, as members of their ingroup (Gabriel et al., 2018). Sheppard and Aquino (2017) identified how women are more likely to experience incivility from other women than men; one of the reasons cited for this was competing for limited resources within the workplace.

How an employee responds to incivility can differ as a result of gender and status, as male targets, (and those of higher status), are more likely to respond aggressively to incivility, especially when the instigator is of equal status. In contrast, low-status and female targets are more likely to distance themselves or avoid the instigator (Porath et al., 2008). Women showed decreased resistance and increasing acquiescence to higher-status challengers, seeing defending themselves as antisocial and irrational (Rothleder, 1992) and believing they should be nice rather than display anger and aggression (Hochschild, 2012). Female targets with jobs requiring higher task interdependence, are more likely to engage in counterproductive work behaviours, but the opposite was true for male targets (Welbourne & Sariol, 2017).

2.5.3 Contextual, job-related and situational factors

Both job-related and situational factors may increase the severity of the negative effects of incivility, as individuals with high job involvement are more likely to respond to incivility by engaging in counterproductive work behaviours, such as production deviance and withdrawal behaviour (Penney & Spector, 2005). Situational factors, such as the days of the week can affect employees' experiences of incivility, as incivility varies in a weekly rhythm, with a 50% drop in experiences from a Monday to a Friday. This is consistent with research on mood which follows the same cycle, as positive mood increases as the week proceeds (Nicholson & Griffin, 2017). To the researcher's best knowledge, no studies have looked at shift work patterns or a seven-day service organisation on levels of incivility.

2.6 Coping strategies

Coping with incivility is a complex and multidimensional process, and how individuals appraise the severity of the uncivil behaviour, will then determine their coping strategy. Such coping techniques include, conflict avoidance, minimisation, seeking both informal and formal organisational support and confrontation (Cortina & Magley, 2009). Often the strategies are multiple, so starting with constructive problem-solving techniques, and if that fails, ultimately leaving the organisation (Zapf & Gross, 2001).

2.6.1 Problem-focused and emotion-focused coping strategies

According to the transactional model of stress, when an individual appraises a situation as potentially threatening to their well-being, and exceeding their resources, they may engage in two forms of coping, that of problem-focused and emotion-focused coping (Lazarus & Folkman, 1984). With appraising a situation

as potentially suitable for problem-focused coping, the individual makes an active effort to eliminate the problem so intending to eliminate the stress, such as through confrontation. Whereas, emotion-focused coping differs as is aimed at managing the emotions that are produced by the stress, rather than trying to eliminate the actual stress source, so introducing behaviours such as, avoidance or reframing techniques. Humour is a well-used social support coping strategy, which builds group cohesion and generates camaraderie (Romero & Cruthirds, 2006; Vaill, 1989). Shared humour is seen as being an identifiable entity (Romero & Pescosolido, 2008) and important to understanding about workplace culture and group dynamics (Levi, 2017).

Certain coping strategies are consistently associated with poor mental health outcomes, such as escapism and avoidance (Hershcovis, Cameron, Gervais & Bozeman, 2018). Other kinds of coping such as, social support or problem-focused forms are associated with a range of outcomes, and these are dependent on the appraised stressful encounter. These coping strategies can have a negative, a positive result or sometimes result in neither outcome (Folman and Moskowitz, 2004).

2.6.2 Outcomes and effectiveness of different coping strategies

Although some studies have examined the range of coping strategies used, few have looked at the outcomes of coping and effectiveness (Cortina & Magley, 2009; Salin, Tenhiala, Roberge & Berdahl, 2014; Zapf & Gross, 2001). When targets were asked retrospectively about their desired response, they generally wished they had been more assertive (Salin et al., 2014). One study that has reviewed coping strategies by Hershcovis et al., (2017) examines the two techniques of confrontation and avoidance. With regards to the reoccurrence of incivility, the coping strategies of both avoidance and confrontation were found to be ineffective.

Being confrontational is a direct response and perhaps can be seen by the perpetrator as conflict, resulting in repeated uncivil behaviour. Alternatively, as incivility is ambiguous, then such confrontations may also be a disproportionately strong response, so again exacerbating the situation. Avoidance as a coping strategy was also ineffective in stopping incivility, as the perpetrator will carry on unaware of any concern. Other coping strategies need to be examined as there may be other techniques in between these extremes that will be more effective (Hershcovis et al., 2017).

2.6.3 Frequency of coping strategies

Examining the frequency of coping strategies, targets used emotion-focused techniques such as ignoring the uncivil perpetrator, more often than utilising assertive strategies such as, confrontation (Cortina & Magley, 2009; Salin et al., 2014). Out of all the strategies used to dealing with uncivil behaviour, reporting the incident was the least frequent, possibly because targets feel the uncivil behaviour could be seen by others as mundane, so not significant enough (Hershcovis et al., 2017). Those who do not fit in or who are different, are likely to be the ones who are subject to workplace mistreatment and can further explain the reluctance to speak up. This may stem from the culture norms of wanting to fit in, and not wanting to appear to be an outsider and seem different (Omari & Paull, 2013).

2.6.4 Avoidance and confrontation as a coping strategy

When targets chose to avoid the incivility perpetrator as their coping strategy, they were more likely to engage in enacted incivility, less likely to experience psychological forgiveness, and more likely to experience emotional exhaustion (Hershcovis et al., 2018). This avoidance coping technique, despite its frequent usage, had detrimental effects, and, consistent with the transactional model of stress (Lazarus & Folkman, 1984), such an emotion-focused coping strategy was

ineffective for eliminating the stressor. However, inconsistent with the transactional model of stress, it was also an ineffective strategy for dealing with the stress itself, as avoidance did not seem to remove the negative emotion associated with incivility, as it is a coping strategy associated with poor mental health outcomes (Folkman & Moskowitz, 2004). It is also ineffective in stopping future incivility, as a consequence of the perpetrator being unaware of any concerns (Hershcovis et al., 2018).

In contrast, those who confronted the perpetrator were more likely to forgive, which is a step towards resolution, and so maybe more of a long-term strategy than avoidance coping. In summary, confrontation as a coping strategy despite not preventing incivility recurrence, provides the ability for the target to exert control by producing a cathartic effect, by letting go of the negative emotion of stress and forgiving the perpetrator (Hershcovis et al., 2017). Given the prevalence of workplace incivility (Porath & Pearson, 2013), little research has been undertaken in other coping responses, such as seeking support and officially reporting the behaviour to the organisation, to determine which strategies would be most effective for dealing with incivility (Hershcovis et al., 2017).

It is generally assumed that interventions such as confronting the perpetrator is desirable, yet more research needs to be undertaken to see if this is the case, as this intervention could mean more incivility and even a secondary spiral as observers also become victims (Andersson & Pearson, 1999). It is also possible that observer intervention could exacerbate the negative outcomes of incivility for the target, as it may draw attention to a situation that the target has chosen to ignore and not confront. The researcher is unaware of further studies in this area, and subsequently, additional research is needed to understand the different conditions where intervention is helpful, harmful, or simply ineffective.

2.7 Protective factors to reduce the effects of uncivil behaviours

Intrapersonal protective factors can help to reduce the negative effect of uncivil workplace behaviours and numerous studies have identified how organisational structures, such as leadership and empowerment can reduce them (Laschinger, Leiter, Day & Gilin, 2009; Smith, Andrusyszyn & Laschinger, 2010). These will be discussed further in section 2.8 of this chapter. Individual factors, such as resilience, self-efficacy and Psychological Capital which act as a protection against incivility, are examined in the sections below.

2.7.1 Psychological Capital (PsyCap)

The relationship between stress and incivility can be moderated by an individual's level of Psychological Capital (PsyCap) and is defined as a positive psychological state of mind, that influences how individuals respond to their environments (Luthans, Youssef & Avolio, 2007) and contributes to decreased stress (Avey, Luthans, Jensen, 2009; Luthans, Avolio, Avey & Norman, 2007). PsyCap is characterised by, having confidence (self-efficacy) to succeed at challenging tasks; optimism about now and in the future, perseverance towards goals, and having hope when goals are redirected, so displaying resilience to succeed (Laschinger & Nosko, 2015).

Individuals high in PsyCap may better cope with work stressors, such as incivility, and as a result respond more positively. For example, individuals low in PsyCap may perceive a situation as threatening, whereas persons with high in PsyCap may not, due to their heightened levels of self-efficacy, optimism, and hope. Additionally, individuals low in PsyCap may react to a threatening situation with negative emotion, whereas persons high in PsyCap would not, as a result of increased resilience (Avey et al., 2009).

In a review of literature on personal resilience in healthcare, Jackson, Firtko and Edenborough (2007) found that PsyCap was essential in helping nurses cope with negative workplace experiences, with optimism acting like a buffer against the negative effects, as well as reducing emotional exhaustion. PsyCap also moderated the impact of stress, so individuals with high PsyCap were less likely to retaliate the uncivil behaviour and not participate in the incivility spiral (Mensah & Amponsah-Tawiah, 2016).

2.7.2 PsyCap in organisational development and learning

Personality dimensions may influence an individual's ability to cope with stress and incivility (see section 2.5.1), although these will be relatively fixed and stable over time (McCrae & Costa, 2004). Whereas, positive resources, such as those represented by PsyCap, are defined as state like (Avey, Luthans & Youssef, 2010; Luthans et al., 2007) so open to organisational learning and development. PsyCap is therefore, unlike dispositional traits, amenable to change, making it particularly compelling to developing this intrapersonal resource in the workplace, through organisational training programmes (Luthans, Norman, Avolio & Avey, 2008). As PsyCap may play some protective role against negative behaviours, it highlights the need and importance of developing strategies to build PsyCap, so to strengthen intrapersonal resources for coping with negative work experiences in the workplace (Lashinger et al., 2009).

According to Luthans et al., (2007) each component of PsyCap strengthens each other, for example, possessing greater self-efficacy may also increase an individual's resilience and vice versa, implying that these components are inter dependent (Avey et al., 2009). As a whole, Psycap is considered a stronger predictor of workplace attitudes and behaviours, than its individual components (Luthans et al., 2007).

2.7.3 Resilience

Although resilience is one of the intrapersonal resources in PsyCap, little attention has been paid to the influence of resilience on incivility, despite the increased focus in recent years (Alola & Aloa, 2018). Resilience is the ability to recover from shock, uncertainty, failure or overwhelming changes (Luthans, Vogelgesang & Lester, 2006; Robertson & Cooper, 2013) and individuals who can bounce back from setbacks and perform better than before, are said to be highly resilient (Robertson, Cooper, Sarkar & Curran, 2015). Resilience is not a fixed state and seen as a very powerful tool to deal with any job stressor. It is important for increasing individual's performance and wellbeing in the workplace (Roberts et al., 2011). Workplace resilience assists employees in succeeding and overcoming adversity, so a necessity for all organisations (King, Newman & Luthans, 2016).

Wider afield, research has been undertaken examining resilience and bullying, although this is predominately among young people and school age children, as studies show how resilience is a protective factor, both in preventing experience with bullying and mitigating its effects (Hinduja & Patchin, 2017). Within school children's experiences of resilience, those with poorer resilience were more likely to engage in bullying behaviors, as well as individuals with poorer levels of resilience were more likely to be victims of bullying (Moore & Woodcock, 2017).

2.8 The role of leadership and incivility

There is an emerging and increasing emphasis on the impact of leadership on workplace incivility, particularly as individuals are more likely to follow the behaviour cues of those with power and social status within the workplace (Clark, 2008). The impact of the leadership is dependent on the style of leader, for instance, transactional leaders focus more on the actual task, (often to the detriment of individuals), that results in a workplace culture tolerating uncivil

behaviour, when it is not related to work outcomes (Hutchinson & Hurley, 2013). Whereas transformational leadership moderates the relationship between incivility and employee wellbeing, as leaders both support and motivate employees (Arnold & Walsh, 2015). Such social and emotional support can help prevent a stress response, by making individuals feel they are valued and supported (Beattie & Griffin, 2014; Miner et al., 2012). Transformational leadership is associated with empowerment and helps to create a more positive interpersonal workplace culture. Such empowerment is associated with increased job satisfaction, retention and autonomy (Kennedy, Hardiker & Staniland, 2015) and plays a key role in decreasing incivility (Kaiser, 2017; Laschinger, Wong, Cummings & Grau, 2014; Wing, Regan & Lashinger, 2015).

Organisations that have a strong emphasis on rank, hierarchy and have a highly authoritarian leadership, are often places of workplace aggression (Salin, 2003). Alternatively, a laissez – faire management style could also be detrimental to the individual who is experiencing incivility, as there often will be few supporting structures (Rowland, 2009). A laissez-faire style leadership, with its perceived lack of response to such incivility, can also act to normalise the uncivil behaviour (Clark, 2017).

2.8.1 Uncivil behaviour from those in leadership roles

Differences in the emotional appraisal of stress after uncivil behaviour is dependent not just on the variety and frequency, but also the role and power of the instigator (Cortina & Magley, 2009). Incivility from higher status individuals is seen as particularly distressing, as targets feel unable to resist or complain, (section 2.3.6) and also supports the literature on workplace bullying and power (Lim et al., 2008). Individuals reported lower mental, emotional and social energy after uncivil behaviour from a supervisor (Giumetti et al., 2013).

When examining civility and leadership, 25% of leaders believe they will be less leader-like and 40% think they will be taken advantage of, if they are too nice at work (Porath & Gerbasi, 2015). Whereas in a study of leaders, respect had the most powerful effect on employees of all leadership behaviours. Respect was more important than recognition, communication, feedback and development opportunities. Those who felt their leader respected them reported 56% better health and wellbeing, 89% greater enjoyment and satisfaction, and 55% were more engaged with work. The study highlighted that it was small pieces of information that conveyed this respect, such as listening, asking questions, giving and sharing credit and positive non-verbal behaviour, such as smiling (Porath & Gerbasi, 2015).

2.9 Incivility in the context of healthcare and the NHS

2.9.1 Organisational context

The recent regime of fiscal austerity apparent in the UK since 2010, has created significant economic, social and ethical challenges for healthcare, and produced conditions that can undermine professionalism within the NHS. Austerity is detrimental as it creates shortages of resources, (such as with staff and material), as well as negatively affecting relationships and organisational cultures (Owens, Singh & Cribb, 2019). Healthcare workplaces may be more susceptible to uncivil behaviours due to these stressful environments, constant changes, challenging and difficult work, large staff numbers and the range and diversity of interactions (Hunt & Marini, 2012). Those who work in the NHS appear to experience a higher incidence of negative behaviour than the private sector, that could be due to the high amounts of stress, pressure and perhaps public scrutiny, as well as the number of organisational changes which could either cause or contribute to the negative behaviours (Quine, 2001). Incivility within medical teams is influenced by

these workplace culture factors which shape and influence behaviours of incivility (Salin, 2003).

The report of the Government Mid Staffordshire NHS Foundation Trust Public inquiry (2013) examined the causes of the failings of the Trust between 2005 and 2009. It recommended over 290 changes, particularly in developing openness and transparency within the leadership and culture of the Trust. Although incivility is not regularly reported in the NHS, workplace bullying is seen as a consistent and persistent problem, and to reduce this, there is a reliance on staff being able to report issues. In the current economic climate, with budget cuts and restructuring, staff may be increasingly reluctant to report these problems (Carter et al., 2013).

2.9.2 Incivility within healthcare – nursing

Workplace aggressive behaviour in healthcare is particularly well researched within Nursing (Kaiser, 2017), and although not the main profession within this study, it is relevant to review this literature; nurses are part of the same multidisciplinary team as Physiotherapists. The role of the multidisciplinary team within the NHS is to deliver integrated care; they have been shown to be an effective tool to facilitate collaboration between professionals, so ultimately improve patient care (Hartgerink et al., 2014).

Nursing is cited as being at a 10% to 15% higher rate of incivility, than non-nursing occupations (Hunt & Marini, 2012). Such negative consequences of incivility are not only regarding the wellbeing of the nurses, but also ultimately impact patient care (Kasier, 2017). As nursing and healthcare are professions characterised by their compassionate and caring ethos, reports of incivility and an unhealthy work environment are somewhat paradoxical in a workplace where care is supposed to be supreme (Hunt & Marini, 2012; Trossman, 2014).

The study of incivility within nursing is particularly notable in the United States and originated from a seminal article, "Nursing: are we eating our young?" by Meissner (1986). It identified how nursing education is focused on judging rather than supporting, where mentors were too eager to destroy their students, with examples of ridiculing the students for being too idealistic in their view of patient care (Meissner, 1986). Although this article was written years ago, this incivility continues with both students and newly registered nurses in practice, as they are vulnerable to incivility behaviours. Such incivility is widely accepted in the nursing workplace (Khadjehturian, 2012; Smith, Morin & Lake, 2018) and even ritualistic in nature (Magnavita & Heponiemi, 2011). Clinical nurses report uncivil acts committed by supervisors, physicians, patients, and fellow nurses (Meires, 2018; Smith et al., 2010) with incivility a major source of dissatisfaction, as well as contributing to high levels of turnover associated with the first two years of new graduate nurses entering the workplace (D'ambra & Andrews, 2014).

2.9.3 Incivility and bullying within Physiotherapy

To the best of the researcher's knowledge, there is no research on incivility within Physiotherapy, nor indeed any of the Allied Health Professions (AHPs). There are limited studies and journal articles examining bullying within Physiotherapy, but these only examine students on clinical placements, so within a student population. One study of bullying in Physiotherapy does mention incivility as part of the range of negative behaviours in the workplace, but again focuses solely on bullying within final year student placements (Stubbs & Soundy, 2013). Although the prevalence of bullying within Physiotherapy as a profession is unclear and unknown, the study found that 25% of students had experienced bullying behaviour on placement, yet over 80% did not report this back to their university of study. The bullying was seen as part of the high pressured, stressful environment, and this produced an

inevitability and acceptance of the behaviour. In other studies, over half of the students did not report the behaviour, as felt they had to just get through the placement, being fearful for any repercussions it may have on their assessment and future career (Whiteside, Stubbs & Soundy, 2014). The Health and Care Professions Council (HCPC) guidelines for Physiotherapy students on placement have recently been updated in 2017, yet do not contain any guidance for students to deal with uncivil or bullying behaviours when on placement. A mandatory session on workplace behaviours should be incorporated into Physiotherapy professional training (Stubbs & Soundy, 2013) empowering students through various coping strategy techniques (Thomson et al., 2017).

2.9.4 Incivility within medical teams - communication

Certain medical specialities are reported as more likely to display uncivil behaviour and be more aggressive in their communication, such as radiology, general surgery, cardiology and neurosurgery (Bradley et al., 2015). In general, communication is often seen as a desirable attribute, rather than an important and necessary clinical skill (Riskin et al., 2015). There is less appreciation of the social skills of a surgeon for instance, and the effect these skills can have on both the clinical team and the patient outcome (Youngson & Flin, 2010). There is an expectation that all the technical skills of a medical team, such as a surgeon, anaesthetist and nurses will successfully blend together, yet these technical skills are not enough to guarantee patient safety, as there also exists a risk from leadership, communication and decision-making failures (Flin, 2010). The problems of team coordination and communication are seen as the single biggest cause of nearly 70% of sentinel events in a hospital setting. Furthermore, medical bedside manner and etiquette is seen to be eroding in general and ignoring such

bedside manners ultimately can affect medical care (Silverman, Stern, Gross, Rosenstein & Stern, 2012).

2.9.5 Medical consequences of incivility – patient error

Contextual stressors, such as rudeness may be linked to iatrogenic events by affecting medical professionals' cognitive processing, as well as communication processes at the team level (Riskin et al., 2015). Iatrogenesis refers to an adverse patient condition that is associated with a medical treatment, such events include a diagnostic error or delay, errors with procedures, or drug doses or failure to identify and respond to diagnostic or treatment errors in a timely manner (Gray et al., 2006). In a survey regarding uncivil behaviours in healthcare in the United States, 77% reported they had witnessed disruptive behaviours in doctors, with 65% witnessing such behaviours in nurses. Of these, 67% said the behaviours were then linked with adverse events, and 71% with medical errors. These adverse events were from preventable events, errors and compromises in safety (Rosenstein & O' Daniel, 2008). Overall, rudeness explained more variance in practitioner performance than any other commonly explored cause of iatrogenesis, even chronic sleep loss (Riskin et al., 2015).

In summary, incivility can hinder effective communications and often cause preventable serious mistakes, ultimately harming or even causing the death of a patient (Clark, 2017). Recent studies estimate that patients are exposed to at least one medication error per day (Riskin et al., 2015), as many medical improvements are directed at refining systems and technologies, ultimately neglecting the role of human and relationship factors. Underlying the impact of incivility on medical practice is how rudeness interferes with working memory. It can adversely affect the cognitive functions required for effective diagnostic and medical procedural

performance, as well as weaken collaborative processes, such as information sharing and help-seeking (Benda, 2016; Riskin et al., 2015).

2.10 Chapter summary and links to the next chapter

This chapter has provided a review of literature examining incivility in the workplace, and why individuals engage in such behaviours, as well as the organisational and individual consequences of incivility. The discussion then focused on factors that can shape and mediate the experience of incivility, as well as the role of problem focused and emotion focused coping strategies. Protective factors to reduce the effects of uncivil behaviours and the role of leadership were discussed, with a final review of incivility in health and social care. Throughout the discussion, limitations of the existing literature were discussed, in particular, highlighting the gap of research examining incivility within Physiotherapy, despite the research that incivility and negative workplace behaviours were prevalent within the NHS. As many of the rationale for such uncivil behaviour, such as austerity and the pressures in the NHS show no sign of abating (Mosley & Lockwood, 2018) then such incivility may also increase. The next chapter will further examine the influence of incivility upon individual experiences, through the qualitative exploration of uncivil leadership in an NHS healthcare Trust.

Chapter 3 Study 1 - Qualitative exploration of incivility and leadership using Template Analysis

3.1 Chapter overview

This chapter outlines a qualitative exploration of uncivil leadership in an NHS healthcare Trust. Template analysis (King, 2012) was used to analyse data from 20 semi structured interviews conducted within the Physiotherapy department. The findings are presented and discussed in relation to six key themes, as outlined below.

3.2 Rationale for the current study

As outlined in the literature review, research examining uncivil leadership in healthcare is mainly within the nursing profession (Kaiser, 2017); within nursing, most research has been undertaken within educational training establishments (Brown, 2016; Clark, 2008; Clark & Springer, 2010) rather than a clinical setting. When incivility research has occurred in such clinical settings, it is predominately within surgery and theatre, examining how teamwork and communication can contribute to surgical mistakes (Flin & Fruhen, 2015). To date, the researcher is unaware of any studies examining incivility within the Allied Health Professions (AHPs), or even incivility within any wider medical area, such as Multi-Disciplinary Teams (MDT).

The focus of this qualitative study was to explore uncivil leadership in Physiotherapy, to determine if it did exist, and if so, to then identify from the narratives the key themes that emerged. These themes would then form the basis of developing and delivering an organisational intervention. The areas to be explored within this study were, good and poor leadership within the Trust, disrespectful leadership and the subsequent effect on the individual. Lastly, the

study focused on how the participants would like to challenge any negative and disrespectful leadership behaviour. The intention of this study was to gain a deeper understanding of these areas, so to inform the design of the intervention in study 2.

Study research questions

This qualitative study aimed to examine the following research questions:

- Does uncivil leadership exist and to what extent is it part of the workplace culture?
- What effects does uncivil leadership have on the individual?

3.3 Approach

Within this section, the approach used to answer the above research questions will be discussed, as well as the epistemological position taken. The use of semi-structured interviews and the method of thematic analysis to code the data will then be examined.

3.3.1 Epistemological position of template analysis

Template analysis (King, 2012) was used to analyse the interview transcripts. This analytic approach is a branch of thematic analysis (Braun & Clarke, 2013) developed as a method for identifying, analysing and then interpreting themes, or patterns of meaning within qualitative data. Thematic analysis is seen as being unusual within qualitative analytical approaches, as it is not a clearly delineated method, but a technique unbounded by theoretical commitments, for organising and then analysing the data (Braun & Clarke, 2013). It occupies a position between content analysis (Weber, 1990) where the codes are predetermined, and grounded theory (Glaser, Strauss, Strauss & Anselm, 2017) where no definition of codes exist.

Research methods cannot be separated from their philosophical underpinnings (Smith & McGannon, 2018), and are informed by the nature of reality and the nature of knowledge, so an epistemology and an ontology (Eakin, 2016; Sparkes & Smith, 2014). As template analysis is a range of techniques, rather than a distinct methodology, it can be used within a range of epistemologies, such as a realist methodology (by uncovering the real truths of the participants), to a more contextual constructivist approach, (assuming multiple interpretations can be made of any phenomenon), depending on the content and the researcher (Madill, Jordan & Shirley, 2000). Somewhere in-between these two epistemologies, (Brookes, McCluskey, Turley & King, 2015) is a subtle realist approach, such as defined by Hammersley (1992) which is the approach adopted within this study. This realist approach acknowledges that a researcher's perspective is influenced by their lack of ability to stand outside their position in the social world. They are part of reality, so cannot be independent of it. The approach however also recognises that phenomena exists that are independent of the researcher. Hammersley (1992) sees social research as aiming to represent reality, but that the representation will always be from a point of view. There can be multiple yet valid explanations of the same data, making some parts of the phenomena relevant and others irrelevant. Subsequently the approach within this study makes claims about the validity of a representation arising from the research, but also recognises other perspectives are also feasible (Brooks et al., 2015).

This approach allows for use of the template in a highly flexible way, to produce an interpretation of the text that is dynamic; this works particularly well within the applied setting of an organisation (King, 2012) as has both structure and flexibility. Such flexibility is particularly favoured when comparing different groups of staff

within an organisational setting (King, 2012) so presents as a good fit for this applied study.

3.3.2 Participants - sample and recruitment

A Physiotherapy department in a large urban NHS Trust was approached, to determine if they would be willing to participate in this study. The NHS Trust was chosen as in the previous year, the researcher had developed and delivered a 360 leadership development and coaching programme within the Physiotherapy department. This programme involved 40 Physiotherapists at various supervisory and managerial levels and lasted over 6 months. It was during these coaching sessions that the issue of disrespectful and uncivil leadership behaviour became apparent, as well as the lack of confidence and self-belief many Physiotherapists felt when dealing with these individuals.

Having discovered this theme of low confidence and self-belief, the researcher felt a professional obligation to explore it further, with the aim of developing a training intervention. The researcher approached the Clinical Lead responsible for the Physiotherapists, to discuss these findings and to see if they would be willing to undertake some interviews. The aim was to develop an intervention to increase confidence and self-belief. The Clinical Lead was enthusiastic about this further work, as had also found this to be an ongoing issue within the department.

Volunteer participants were recruited via an email from the Clinical Lead and asked if they would be willing to be interviewed. These participants were recruited from the original group of 40 Physiotherapists in the 360 leadership development and coaching programme. Due to operational constraints and demands, it was agreed that only half of the original group could be interviewed, so a maximum set at 20 participants, although as discussed below, this was a suitable number for qualitative research.

3.3.3 Sample size

Although there are no specific rules for sample size in qualitative research, the aim is to have sufficient participants to provide data for a rich story, but not so much data that it prevents a deep study in the available time (Onwuegbuzie & Leech, 2005). A sample size of between 15 to 20 tends to be common for individual interviews (Terry & Braun, 2011). Braun and Clarke (2013) recommend that with semi structured interviews (as used in this study), a suitable sample size should be small to moderate. The sample size needed to be small enough to retain a focus on the experiences of the individuals involved, yet large enough to convincingly demonstrate patterns across the data.

3.3.4 The organisation – an NHS Trust

The organisation was an Acute NHS Trust in the North of England, supporting hospital and community health care services across the county. The Trust employs around 8,000 staff and has over one million patients every year.

3.3.5 Materials

Interviews were chosen as they are suited to research that examines experience, looks at understandings, perceptions and various practices (Braun & Clarke, 2013). In preparing for the interviews, an interview guide was first designed, providing a series of questions to be asked to guide the conversation. These questions were organised into topic-based clusters and ordered to flow in a logical sequence. The technique of funnelling questions was used; interviews starting with more general areas, before focusing on more specific questions, providing a flowing and a logical progression. The interview schedule started with an open and easy introductory question, asking the individual how long they had worked for the

NHS and also the Trust, with the aim of building initial rapport (Braun & Clarke, 2013).

As well as the main questions, prompts and probes were also designed (Braun & Clarke, 2013), such as asking how the participant would challenge uncivil behaviour and for examples of behaviours. At various points the techniques of probing, clarifying and summarising were utilised for further details or to aid clarity. Throughout the interview, particular attention was paid to the wording used, as it needed to be recognisable to the area of interest, but not too closed or loaded (Smith, 1992).

The draft interview guide needed to be scrutinised; this was reviewed by the author of this thesis, as well as an experienced qualitative researcher. It was important to understand whether the interview questions would help to answer the research questions, as well as ensuring there were no problematic assumptions and that the interview schedule would be meaningful to the participants. It was also decided at this stage to use the word disrespectful leadership rather than the terms uncivil or incivility, as these were used more within academic literature, rather than everyday organisational life. The questions were re-worked numerous times to obtain the final interview schedule, although as recommended by Charmaz (2014) a qualitative interview does not need to be fixed at the start of the interviews and can evolve as new issues arise. The schedule was reviewed after the first series of five interviews, although a revision was not seen as necessary.

3.3.6 Interviews

The interview schedule (Appendix A) is based around the research questions as outlined in section 1.5. The main areas within the interview schedule were:

- Job details

- Leadership within the Trust
- Dominant and disrespectful leadership and the individual
- Dominant and disrespectful leadership, and the team and culture
- How the participant would like to change the behaviours

3.3.7 Audio Recording of the interviews

Audio recording was chosen as it fitted the rationale of this research, to ascertain the richness and depth of the participants experience. The recording would provide an accurate record of the language used and was undertaken with a digital MP3 player, placed on the table by the side of the participants. Although details of the recording were described to the participants in the pre information, the researcher always mentioned the use of audio recording again at the start of the interview, ensuring the participants were content with its use. A consent form for the use of the audio equipment, (as well as the interview being recorded), was signed by the participant at the start of every interview, (Appendix B).

3.4 Procedure

Semi-structured interviews took place within one of the main hospital sites during May 2016 to July 2016. Due to shortage of space and operational demands, these were conducted in various settings, including the Clinical Lead's office, the staff restroom, a staff kitchen, a patient consulting room and the Physiotherapy hydrotherapy room. As the researcher was aware of the pressures and organisational demands of the environment, refreshments and snacks were provided on arrival to help participants feel welcome (Braun & Clarke, 2013). It was also hoped it would be a way of helping them to relax, having just left the clinical environment a few minutes before.

As participants entered the interview room, they were given a participant information sheet describing the study (Appendix C), as well as details of confidentiality and data storage. They were reminded of the voluntary nature of the study and provided with details of how they could withdraw at any time. Participant consent was then obtained (Appendix D) as well as the consent to record the interviews, as discussed above (section 3.3.7). The anonymity of the interview was stressed, with reassurance that if the participants mentioned any names by accident, these would be deleted and recorded as a blank on the actual transcripts. Ethical approval was gained from the Psychology Ethics Committee, School of Life Sciences at Northumbria University.

The interviews lasted on average 29 minutes, with the shortest being 15 minutes and the longest 52 minutes. An informal and relaxed feel was important in enabling an open and honest conversation. As the researcher was known to all the participants (through the previous 360 leadership development programme), it was anticipated this would be beneficial, as mutual trust and respect had previously been established. This trust was confirmed by a number of participants when discussing confidential examples in the interviews, and it was hoped this previous relationship would increase the richness and depth of the conversations. Due to the operational location of the interviews and clinical nature of the role, 3 interviews were disturbed. There were 2 disturbances from the participants pagers and 1 interruption from someone at the door, urgently needing patient notes from the room. Again, due to the operational priorities and restrictions on time, many clinicians used the interview as their food break and so ate their breakfast or lunch whilst being interviewed. This was welcomed by the researcher as this not only helped to encourage a relaxed atmosphere, but it was hoped it indicated that the participant felt relaxed in the researcher's company. All participants commented

they welcomed the time away from the clinical pressures, with quite a few saying they really enjoyed the interview and the opportunity to think about the question areas.

On completion of the interview, the participants were thanked for their time, reminded of the confidentiality and their right to withdraw. The procedure to obtain feedback was also explained and participants were handed a debrief sheet (Appendix E). The interviewer again stressed the anonymity and confidentiality of the interviews, as well as the procedure for deleting names, given that many participants had mentioned the names of consultants when the recorder was switched on.

3.5 Transcription

The recorded interviews were then transcribed verbatim, often called orthographic transcription (Braun & Clarke, 2013) by transcribing spoken words, as well as other sounds, such as laughing. All transcripts were anonymised, and names that were accidentally mentioned in the interviews were blanked out for confidentiality reasons. The transcriptions were then checked and examined for error or omission before data analysis. Quotes included in this thesis are from the original transcripts; identifiable information was either anonymised, or where not possible, deleted, to protect the individuals and organisation involved.

The process of reflexivity was important at this stage, to take account of self in the process, so being aware of how both the object of the study and the researcher can affect one another (Alvesson, Hardy & Hartley, 2008). These areas of reflexivity will be discussed further in chapter 7.

3.6 Data analysis

3.6.1 Developing the template

In developing the template, the procedure from King (2012) was followed, with the first step for the researcher to become familiar with all the interview scripts. This was undertaken by reading through the data set, so all 20 transcripts. The second step was a preliminary coding of the data. This occurred by developing some a priori themes, although these were seen as tentative and were consequently redefined and changed throughout the coding process (Brooks et al., 2015). This method of the development of the a priori themes, is synonymous with the epistemological subtle realist approach, so instead of developing strong well-defined themes. The pre-defined a-priori themes were based on the question areas in the interviews, as well as those areas which were often probed further in the actual interview (Appendix F).

The codes were organised hierarchically with the main question areas from the interview being higher-order codes, such as '*challenging the behaviours*'. The subsidiary questions in these areas, such as regarding '*respectfulness*', '*challenging unsuccessfully*' or '*ignoring the behaviours*' were used as lower order codes (King, 2012). The themes were developed where the richest data was found (Brooks et al., 2015), and as each transcript was coded, (depending on how the themes were related to each other), they were organised into meaningful clusters, developing hierarchal relationships and a systematic order (King, 2012).

3.6.2 Initial coding Template Revisions 1-3

The initial a priori coding as described above, was used to systematically work through the first transcripts, with the researcher identifying sections of the text relevant to each high and low order code (King, 2012). After five interviews, an

initial coding template was designed that was based on this subset of the data, and which acted as a cross section of the experiences in the interviews (Brooks et al., 2015).

This initial template, called Template 1 (Appendix G) was then applied to further transcripts; when themes did not fit the new data, the template was modified, or sometimes themes were deleted or added. As a result of reviewing these 8 transcripts the initial template was refined to accommodate the identified additional codes, such as '*hierarchy*', that was not a direct question asked during the interview and therefore not part of the original template. During this coding stage, if some of the original codes were not supported, they were kept in the template in case they became relevant with the coding of further transcripts. Some themes were found to overlap, or were too broad or too narrow in meaning, so a continual redefinition of the themes was essential (King, 2012).

A further modification during this stage was changing the higher order classification, as codes initially classified as a lower code were then seen as higher order, for instance regarding '*challenging the behaviour*'. These amendments continued to occur through template version 1 through to version 3 of the template. This process was seen as a cyclical act of recoding the data (Saldana, 2009) and this iterative process continued throughout the coding of all the transcripts.

3.6.3 Scrutiny and reflexivity

Being a sole researcher, an outside adviser was used to collaboratively review the coding used and to counteract the researcher's own assumptions. As a method of independent scrutiny (King, 2012), a sample of template 2 and also one of the interviews was given to an external expert, (the researcher's supervisor), who was both familiar with the research and an experienced qualitative researcher. Following this review a meeting was convened to discuss the findings and template

3 was developed to incorporate the feedback (see Appendix H for detailed changes).

To provide a further quality process within template analysis, King (2012), also recommends researcher reflexivity that is used throughout the process of coding. Such reflexivity requires the researcher to be explicit about any decisions made during the coding process. One such decision regarded the terms of dominant and disrespectful, that were used during the interview questions, but during the coding there did not seem any distinction between the different terms, as the interviewees always discussed rude and disrespectful leadership. The term dominant did not feature at all as a theme during the interviews, so was deleted during the iterative coding of the transcripts.

3.6.4 Member checking

Member checks involve the participants assessing the trustworthiness of the data to assess if the data is credible. Despite being a method of rigor used within qualitative data, this was not undertaken in this study, as it assumes epistemological foundationalism, which is neutral and objective. Methods cannot be unbiased, as they are dependent on the researcher and the participant who are unable to separate themselves from the social world (Denzin, 2017, Smith & McGannon, 2018). Such a method would be in contrast to the epistemology used within this study, as the researcher and the participant will always influence the method. Understanding people's experiences requires interpretive activity, so will be informed by the researcher's assumptions and values (Braun & Clarke, 2013). There is also an incompatibility of epistemological constructionism and ontological realism (Smith & McGannon, 2018), and consequently why member checking was not adopted in this study.

3.6.5 Iterative coding: Template revisions 3-5

Following the scrutiny quality process and the resulting alterations of the template, version 3 could now be applied to all the other interviews; however as outlined above, constant revision and reflexivity of the themes was still applicable and necessary (King, 2012). This revision involved refining, adjusting and revising the hierarchical order of the themes and sub themes to produce template 4. This version was used to finish all 20 of the interviews, although it was found that the new theme of *stress* had strongly emerged through the last six transcripts, resulting in version 5 of the template being developed (Appendix I).

Template 5 was then applied to the rest of the transcriptions, by reviewing, recoding and scrutinising all the 20 transcripts for the new theme of *stress*. As identified by Brooks et al., (2015) there is never a final version of the template, as evident in this study. The continual engagement of the data required further refinements, as discussed in the next section.

3.6.6 Interpretation

After completion of template 5, (and coding of all the 20 transcripts), the interpretation and writing up of the themes could begin. It was during this stage, that more modifications of the themes became apparent. According to King (2012) it is important to ensure that as much justice is done to the richness of the data, and so writing up should still be a continuation of analysis and interpretation. Through selecting illustrative quotations from the interviews, some of the resulting lower codes were combined to form version 6 of the template, which was subsequently used in writing this chapter (Appendix J). The results below are a coherent story of the findings and the researcher's interpretation of the phenomena that this study investigated.

3.7 Findings and discussion

The findings are presented within the next sections and the remainder of this chapter. The template provides a framework to present the themes that were identified, with the inclusion of participant's quotations to illustrate them further. These quotations provide evidence for the analytical claims and allow the reader to judge the researcher's understanding and interpretations of the data (Braun & Clarke, 2013). Subsequently, the themes and relevant sub themes are discussed in this chapter and presented as below:

- What it feels like to work with these leaders
- Hierarchy
- Why they behave that way
- Patient care
- Workplace culture and leadership culture

3.8 What it feels like to work with these leaders

Although a direct question was asked about disrespectful leadership and how it makes the participants feel, this theme was also apparent in many other places in the interview, such as when describing good or poor leadership, how behaviour affected their team or when discussing example situations. It was an integral theme running through all the interviews and often related to other themes, including for instance, respect, how the participants would like to challenge the behaviours or workplace culture.

This section will examine the impact of the consultant's behaviour on the individual, as well as the stress and rumination involved. Coping strategies will then be discussed, in particular looking at avoidance. Lastly, this section will focus on how

the incivility made the individuals more reflective of their own behaviour, and finally the enjoyment of working with some consultants will be examined.

3.8.1 Impact of consultants' inconsistent behaviour

There was a range of individual impacts resulting from the disrespectful and uncivil behaviour, and many participants discussed feelings, such as being upset or unmotivated; these are examined further in this section. These feelings often stemmed from a strong underlying theme in all the interviews, in that the participants wished the consultants would be more consistent and predictable in their behaviour, with many saying all they wanted was simple politeness,

I think one of the consultants has a very short fuse and you never quite know which person you're gonna get so sometimes he's incredibly polite he's incredibly complimentary and then on another day he just doesn't wanna speak to anybody he won't say hello to you as you walk on the ward and you're thinking oh no I need to go and ask him something and you just never know what you're gonna get when he walks through the door he'll either be incredibly polite to you or he'll just completely ignore you and I find that really difficult I'd rather he just did one or the other and then I know what I'm going to get when I go in to see him (participant 16)

Yeah and then other times, you think that he's got a hidden agenda almost, and then other times you go in and he'll give you a one word answer and you're just out the door there's just no point even going there with him so he's quite he's difficult to predict you don't know what mood he's going to be in you don't know how you're going to find him. He's very pro-physio saying that which is bizarre because he's helped quite a lot with our service development but to try and communicate with him is very difficult (participant 17)

The participants discussed how difficult it was to predict the consultant's behaviour and also confusing not knowing what mood to expect, even to the point of one participant commenting they would rather the consultant was difficult all the time, to provide consistency. This is supported by the literature review, where a lack of everyday courtesy and moody behaviour is often viewed as mundane (Andersson & Pearson, 1999; Giumetti et al., 2013; Pearson et al., 2000; Porath & Pearson,

2013; Welbourne & Sariol, 2017) yet the impacts on the individual are wide ranging and far from being just mundane (Cortina et al., 2017; Cortina & Magley, 2009).

The extracts below further identify individual impacts and how the uncivil behaviour ultimately affects wellbeing, with a loss of confidence, motivation and self-esteem (Hershcovis, 2011; Martin & Hine, 2005),

I think it can demoralise people, it can make you unmotivated working alongside someone who you feel doesn't respect your clinical opinion (participant 20)

I think it definitely knocks your self-esteem and it makes you question yourself I think a bit more and I guess reflect more on the scenario (participant 14)

As identified in chapter 2, individuals reported lower mental, emotional and social energy after uncivil behaviour from a supervisor (Giumetti et al., 2013). The resulting effects of these individual impacts also influenced discussions about patients, and so ultimately patient care (see section 3.11).

Many participants commented how such unpredictable behaviour not only affected them personally, but further identified the impact on their teams, such as through increased sickness rates (Pearson et al., 2001),

Massively I think that time period was a time of absolutely unrivalled sickness in the nursing team so I think that was the first thing to happen you get a loss of morale as soon as that happens people haven't got that motivation to come to work when they're not quite feeling one hundred percent (participant 10).

3.8.2 Stress and rumination working with them

A significant source of stress reported by the participants was attributed to the anticipation of events, and rumination about the future behaviour of the consultants. Rumination is self-focused thinking, which involves abstract and passive negative thoughts (Niven et al., 2013) with participants describing how

they would anticipate certain consultants being on duty,

I suppose you do get quite apprehensive the week that they're on you're just waiting for everything that they're gonna come up with that you're gonna them have to go and say look can we discuss this knowing you're not gonna get very far (participant 2)

A common example of rumination discussed in the interviews was needing to prepare more thoroughly for patient discussions with certain consultants, as they anticipated only being given a short amount of time to speak, before being “waved off” or dismissed. Such behaviour was described by many as intimidating, and again cited by many participants as having an impact on patient care.

I think it can you kind of always feel as though you kind of you need to be prepared if you're going to have a conversation you know about say a patient or a clinical situation with that particular person cos you feel as though something may well come back at you or a response may come back that you may feel that you need to respond to (participant 11)

I think I'm quite wary when I'm around him and whereas with the majority you know all the ward doctors, the nurses and everybody you feel like you can kind of have a bit of a conversation like I'm quite concerned about this patient, with him I kind of feel like I have to, I almost feel like in my mind I've got ten seconds to tell this consultant my concerns what am I gonna say you know rather than being able to say I'm really worried about them, I have to be one hundred per cent confident in what I'm about to say and be able to convey that confidence and I find that quite hard. I think I find him quite intimidating because I think to myself I have so few opportunities to actually prove my abilities that I've got to whatever I say to him every time I have that contact it has to be a positive (participant 13)

In these extracts the participants are worried, anxious and intimidated about engaging in a conversation with the consultant, and how they are unable to properly discuss patient concerns. In both extracts, the participants describe having to prepare their question, that they indicate is difficult and intimidating, as all they want is an open discussion. The consultant gives them limited time, so closing the conversation, and again impacting patient care.

Persistent worrying and rumination is frequently associated with the impact of uncivil behaviour (Pearson et al., 2001; Porath et al., 2008) but typically the focus in the literature is related to distress after an uncivil event (Park et al., 2018) and the recovery (Demsky et al., 2019), rather than the anticipation. Negative work rumination is associated with both active cognition preoccupation, trying to solve a problem that has already occurred, or in anticipating future work problems or tasks (Demsky et al., 2019) rather than anticipating uncivil behaviour (Judge & Ilies, 2004). Within the literature examining workplace violence, individuals with a higher tendency to ruminate, had a stronger negative relationship between exposure to violence and poor health and well-being, compared to those with a lower tendency to ruminate (Niven et al., 2013). The author is unaware of any studies examining the effects of rumination and incivility, and in particular, in the anticipation of future events and conversations, so highlighting a gap in the literature.

3.8.3 Coping strategies

The Physiotherapists discussed using many different coping strategies when working with uncivil and disrespectful leaders. Some participants directly used the word coping, whereas others indirectly talked about strategies they employed with uncivil behaviour. Many participants used the coping technique of reframing and rationalising the behaviour (Hershcovis et al., 2018; Lazarus & Folkman, 1984) for example, focusing on the parts of the job they enjoyed,

No I don't enjoy working with them I still enjoy my job working within that team you know when I was working with the person who was the leader that I didn't particularly think was a good leader, I still enjoyed my portion of the job but I had to sort of compartmentalise and go right I'll go and do my work now because you didn't feel like you weren't, you had to sort of cut that bit out in order to survive the rest of it (participant 5)

Team support and the use of humour was also often referred to by participants and in particular, during certain times, such as shift handover. The timing of the humour,

both before and after a shift, may be a further indicator of a coping strategy used to cope after uncivil behaviour, or to assist with rumination and anticipation of incivility later in the shift,

think there's a definite different, if we know if he's the consultant of the week there's a definite oh he's consultant of the week we won't be able to do this he's gonna tell us what to do and I have to say sitting when we're sitting getting handover if we know he's there we can be a bit unprofessional and disrespectful actually (participant 3)

because it gives you something to have a giggle about and you bond with the rest of the team (participant 17)

One participant discussed how personal humour, in the form of being mischievous was important when coping with incivility, identifying it as a coping strategy on both a team and individual level,

when somebody has a very parental personality and is starting to talk down to me that puts me back into school and I wasn't very good at school and I don't really cope with authority so when somebody stands up and starts doing the classic school teacher spiel that brings out the worse in me that takes me straight back to school, so it brings out the mischievous child rather than somebody who has to work with them (laughs) (participant 8)

Coping strategies are multidimensional and as identified in the interviews, humour is a well-used coping strategy, to build group cohesion and generate camaraderie (Romero & Cruthirds, 2006; Vaill, 1989). It was often discussed by the participants alongside informal organisational support, such as team bonding (Cortina & Magley, 2009; Hershcovis et al., 2018). Shared humour is seen as being an identifiable entity (Romero & Pescosolido, 2008) among teams and important to understanding about culture, leadership and group dynamics (Ponton, Osborne, Thompson & Greenwood, in press).

3.8.4 Avoidance

Avoidance as a coping strategy was often discussed by participants but mentioned in a range of different examples during the interviews. Many commented how the consultant's presence had an impact on the atmosphere and there were numerous examples of Physiotherapists hiding in various parts of the ward to avoid any contact,

Yeah, yeah I think you could see the staff that weren't comfortable with him you know shrunk into the wall you know if he came in it was like oh definitely don't even want to be here let alone stand up to you, if you needed to ask him a question it was always a case of you go, no you go, no one wanted to go and ask the question and he was just known for being difficult awkward and just not very helpful really (participant 9)

Some participants were insistent on not avoiding the consultant, (despite their uncivil behaviour), stressing they needed such contact for the sake of the patient. The area of avoidance was particularly noticeable when the participants discussed incivility directed towards their team, as some allowed their team to avoid the consultant, by undertaking all the communication on their behalf. This highlights an interesting leader and team dynamic, that will be discussed further in section 4.2.

Oh he doesn't bother me at all, no I wouldn't give him the satisfaction of bothering me, I don't enjoy it when he's on the ward but you can hide behind your professionalism can't you and you just put that mask on and do what you have to do and say what you have to say and just get on with it, I wouldn't seek him out to have a chat with him (participant 4)

No I wouldn't avoid contact with her it'd be of a case of (sighs) she's on today that sort of thing, I wouldn't be happy about having to have contact with her if you know what I mean but you've got to work with people that you've got to work with on you know that sort of basis haven't you and you've still got to do what you need to do with that person it's just not a pleasant experience (participant 12)

Also evident within these extracts is the lack of adopting assertive strategies, such as confrontation when dealing with the uncivil consultant. In support of the literature previously discussed in chapter 2, the coping strategy of conflict avoidance was more frequently used than assertive strategies (Cortina & Magley, 2009; Salin et al., 2014) consistent with the situations and strategies described in the interviews and extracts above. Avoidance does not seem to remove the negative emotion associated with incivility, as associated with greater emotional exhaustion, enacted incivility and less forgiveness (Hershcovis et al., 2018). Avoidance is also a coping strategy associated with poor mental health outcomes (Folkman & Moskowitz, 2004), as well as being ineffective in stopping future incivility, as a consequence of the perpetrator being unaware of any concerns (Hershcovis et al., 2018). This is apparent in the extracts above.

3.8.5 Frightened

Whilst feelings of apprehension, anxiety and rumination were frequently discussed by participants, a few also described more extreme feelings of being frightened and feeling intimidated. These feelings were only expressed when the consultant displayed more aggressively overt behaviour, such as shouting or invading their personal space by standing too close to the participant,

I think in a way yeah but more frightened of them to be honest (participant 2)

I found her very intimidating, very aggressive at times and I see it wasn't me I see that now, but at the time I found it very upsetting cos she was very aggressive, put me on the spot a lot, questioned me in a fairly derogatory way rather than a supportive way (participant 20)

Although such examples of being frightened were less frequently discussed, this aggressive uncivil behaviour is identified in the literature as having more of an extreme individual impact, causing psychological distress (Pearson et al., 2000).

3.8.6 Made me more reflective of own behaviour

The experience of working with uncivil consultants made the Physiotherapists more reflective of their own behaviour. This ranged from discussing the individual effects the behaviour had on them, such as lowering self-esteem, to reflecting on their own leadership style and how also they would like to challenge such uncivil behaviour.

An impact that was frequently noted by participants, was how coping with such uncivil individuals had also changed their own behaviour, with participants discussing how it had increased their personal resilience. Although this area of resilience was not a question in the interview, it was often referred to by the participants,

It developed me as a manager I got a lot from working with her in the way that I was then very conscious that I didn't want behaviours sort of like that so I definitely developed my style on the back of it, the time period itself was an enjoyable time with the team that we had but I didn't enjoy working with her but it's definitely made me a better manager (participant 1)

it certainly made me a bit tougher so I think my resilience improved in terms of dealing with things like that and I think I was sort of a lot quicker to stand up for things that I might not have witnessed myself because of that so sometimes I might have got it wrong but I think as soon as someone sort of attacks your team you defend (participant 10)

The area of resilience has been extensively researched in the workplace, highlighting its importance for employee performance and well-being (Robertson et al., 2015). There has been little research on incivility and resilience (Alola & Aloa, 2018); furthermore, the researcher is not aware of any studies on self-reflection and changing behaviours after experiencing incivility in the workplace, so identifying a literature gap.

3.8.7 Enjoyment working with some of the consultants

When the participants were asked about consultants or leaders they enjoyed working with, there were some examples, that often and inadvertently described the negative behaviours of the uncivil consultants. In the extract below, the participant identifies how the consultant would listen and have an open discussion, resulting in changes in patient care. This example is in stark contrast to many of the extracts above, where such open communication regarding patients was closed down and restricted by the consultants,

Yeah, absolutely, and he lets me and he acts upon it which I think I'm very fortunate. I'm not afraid to pass my opinion and he will listen to it, and if he disagrees he disagrees but actually on a number of occasions he will go yeah I totally agree and change clinical practice because of a physio's opinion (participant 20)

The extracts in this section not only provide examples of positive behaviour, but the words used identify how much the individual enjoys working with the consultant. Words such as, mutual respect, relationships, communication and leading are in contrast to many words used to describe the uncivil consultants and their behaviour. In support of the literature, communication and interpersonal skills are a key component of medical team performance, resulting in improved clinical performance and patient care (Youngson & Flin, 2010).

The extract below, discusses the participant's view of an ideal consultant and examines in detail why they enjoy working with them. As well as highlighting the high standards of clinical care, the individual emphasises the quality of patient care, as well as the mutual respect between the professions,

so there's a consultant who as I touched on who I work with and very closely cos we're currently trying to develop a pathway for patients when they come onto the ward and it was sort of a mutual kind of approach to each other almost about doing this and it was our ultimate aim is to look at improving patients quality of life by addressing their symptomatic control while they're in hospital and we're looking at how those patients are identified when they're

first admitted. This consultant to me is a consultant who is how consultants should be on oncology, she thinks about the patient and their quality of life rather than clinical outcomes and how much longer we could give this patient so she looks at quality over quantity which is one the things that I really like about her and really respect her for, I look at how she communicates with other people she talks to everyone like they're a human being not I'm a consultant I'm going to come on here and bark lots of orders and then leave, and she very much gets people on board if she wants their help, she speaks to patients as well like they are people and she works she tends to see a lot more of the sort of palliative end of life patients anyway and the way in which she conveys that to patients I think is, which you know is a real kind of bomb to drop on people even if they're expecting it, the way in which she does that you see in the patients afterwards if you go and speak to them a day or two later and they will say oh doctor so and so came and spoke to me and this is what they said and you sort of say to them do you understand everything and yeah she sat there and she will spend the time with the patients and you know it's not always this you can see them backing out the door she's not like that and I think that from conversations that I've had with other doctors and from having the opportunity to work alongside her she is an excellent leader in the fact that she is doing, she's leading by examples which is actually how things should be done (participant 13)

As identified above, another area of enjoyment derived from working with a consultant was regarding professional respect; participants would always emphasise how this was different to the norm. Such respect was described as amazing and they indicate how fortunate they are to work with such consultants, highlighting how unusual and somewhat unexpected these relationships were. Such civil behaviours positively affect the workplace through increased performance, helpfulness and being cooperative (Riskin et al., 2015).

They respect me as a physiotherapist so they are a consultant and the respect my clinical opinion but I think it takes years to build up that respect and we often haven't got that time within the NHS but he respects me as a physiotherapist and respects my clinical opinion and will listen to my clinical opinion which I think is amazing for a consultant I think some consultants find that very difficult if their opinion is being questioned and particularly being questioned by another clinical speciality (participant 20)

When describing consultants who the participants enjoyed working with, their clinical specialism and knowledge was always the first primary factor mentioned. If the consultant also excelled at patient care or had a good bedside manner, it was

mentioned, but almost as an unexpected bonus, rather than a required element of their role. These communication skills were seen as a desirable attribute, rather than an important clinical skill (Youngson & Flin, 2010), and consequently, when these skills were apparent, it was highlighted as an area of enjoyment for the participants. In the extract below the patient relationship was discussed as the rationale for their enjoyment of working together,

he's excellent with his patients which is lovely to see and his sort of bedside manner as such is fantastic and he's not governed by timescales if somebody wants to come in and offload war and peace to him in essence he will listen and respond and the patient actually feels like they've had a good service and been listened to and they've had a chance and I think that's quite, cos I've previously worked with different consultants who are very much a, b, c, out but he gives the patient that opportunity you can definitely see the patients value that (participant 14)

In the extract above, when the bedside manner is fantastic, it becomes more noticeable, and in support of the literature, medical bedside manner and etiquette is seen to be eroding in general (Gross et al., 2012). As discussed further (see section 3.11.1) ignoring bedside manners and civil communication, ultimately effects the medical care (Silverman et al., 2012).

3.9 Theme Hierarchy

The concept of hierarchy often occurred in the participants' interviews, despite there being no direct question in the schedule. It often arose when the participants were discussing a situation or answering another question regarding respect or leadership. Hierarchy also related to the theme of workplace culture and the culture of leadership. This section will first look at the negative ways that hierarchy was talked about in the interviews, and then examine how it was discussed in a positive light when identifying organisational and cultural change. The terms god-like, old school and the influence of power will also be examined in this theme.

3.9.1 Hierarchy on a day to day basis

Some participants used the actual word hierarchy, whereas others referred to a hierarchical structure through certain words, metaphors or examples. Participants introduced the word hierarchy into the conversation in various, but often tentative ways,

it's almost it's like a hierarchy isn't it sometimes consultants see themselves at a certain level and then everybody else is sort of down the chain (participant 14)

I think there's a hierarchy isn't there within the hospital and you've got you sort of respect those at a more senior level than yourself and you tend to not question or not question as much those that are a more senior level than yourself (participant 2)

These extracts demonstrate the awareness of hierarchy on a day to day basis and how participants are attuned to their social status (Anderson et al., 2006) through an acceptance of power and hierarchy influencing the workplace (Klingberg et al., 2018; Salin, 2003). Throughout the interviews, hierarchy was linked to uncivil behaviour, that was often discussed as undermining the individual,

I immediately go back to I'm in head teachers office, the communication of the individual that I'm thinking of always makes me feel small and I don't know whether that is deliberate on their part whether they're generally like that with everybody (participant 8)

In the above extract, hierarchy is compared to the structure of a school and in a similar manner, many participants did not actually mention the word hierarchy, but used various hierarchical language to describe the consultants, such as metaphors, similes or images. Interestingly, these metaphors all had negative connotations, as though the participants did not want to openly admit the undesirable aspects of a hierarchy, so found the use of such language helpful in describing the situation,

*I think potentially a little bit like a dictator almost it's this way or no way
(participant 14)*

It's cos you're an underling (participant 7)

Using different language to discuss uncivil behaviour can often be used to alleviate some of the hopelessness the individual feels about the situation (Lutgen-Sandvik & McDermott, 2011). In cases of workplace bullying, individuals often use the metaphorical language of children (Tracy, Lutgen-Sandvik & Alberts, 2006), although the researcher is unaware of any studies examining the use of metaphors in the area of incivility. This could potentially provide a rich source of data as well as possibly helping to alleviate the frustration of the individual, when encountering uncivil situations.

3.9.2 God like

Similar to the use of metaphors above (section 3.5), participants often described the consultants as “god-like” and this was always used in a negative context when describing uncivil behaviour. The word was commonplace during the interviews, so suggesting it was an everyday term, used to describe the hierarchy and power within the Trust,

I think a lot of it comes down to is about the respect that people have for each other in their own professions and how there is to me too much am I allowed to say god-like complexes around here? (participant 13)

Some of the consultants and I shouldn't say just consultants but doctors some of them are really sort of aloof not easy to approach and you know that sort of god complex kind of thing (participant 5)

The term was also used as a measure to describe changes in the organisational culture, as incivility is closely related to the culture of the organisation (Leiter,

2013; Salin et al., 2014). In particular, it was used to gauge how the uncivil behaviour of consultants had improved over the years,

I think it's becoming a lot less common I think when I first started thirteen years ago consultants were these god like creatures and often that was I think a persona that was thrust upon them that other people saw them that way so we would treat them that way then you get I guess some sort of god complex or something or you just expect to be treated that way (participant 1)

but I think times have changed because years ago I think they were very much the gods weren't they but not many of them now to be fair are like that participant 5)

The language that is used in relation to organisational culture expresses membership and belonging to certain groups (Schein, 1993) and the phrases in the extracts above, and in section 3.9.3 below, identify common language used within this group of Physiotherapists.

3.9.3 Old school consultants

Rankism and the subsequent use of hierarchical power were often apparent in the term “old school” that was frequently mentioned in the interviews. This occurred when discussing situations of uncivil behaviour, and in examples of culture, power or leadership. The extract below identifies how this term was used in everyday language, to describe a certain type of consultant,

Well I suppose it's possibly their training I guess if they worked with an old school consultant that treats people that way I suppose they learnt from their mentor (participant 9).

The theme of “old-school” was used similarly to the term “god-like” and both descriptions were often used to describe how things had changed and developed within the Trust. This was seen as a measure of culture improvement (Leiter, 2013) demonstrated through the changing levels of acceptance and tolerance of

workplace incivility (Power et al., 2013). Participants would often comment how there are fewer old school consultants than in previous years,

I would say it was common, there's one, two, three, four, five, six there's seven consultants it used to be that there were three of them, two women and one still remains and a male and that was very much old school, of that now we have four new ones and she's the only one that remains of old school so the rest are all into kind of social media and into normality (participant 8)

When discussing positive relationships with consultants, the participants would always use language to demonstrate how different and special that relationship was, so for instance how they felt "lucky" to work with a consultant who sees them as an equal. This highlighted how the culture, hierarchical structure and certain expectations of roles were still engrained in the workplace,

I think because I've worked in the Trust for a long time I've seen a lot of changes within the leadership styles with different managers who have come and subsequently left and I think it's improved for the better, I think it's less hierarchical than it was seventeen years ago and I think we're much more involved with the vision of the service that we previously were. I think within the context of consultants I think the same I think it's improved for the better I think we're more seen on a level than we were when I first qualified, again I don't think it's as hierarchical as it was and I think I'm very lucky in the fact that I work with consultants who very much believe that we work on an equal (participant 20)

The use of the term "lucky" is consistent with recent NHS data; a 2012 NHS survey identified a sharp increase in bullying and harassment by staff. These figures increased from 15% in 2005 to 24% in 2011, identifying how negative workplace bullying caused by senior leaders and doctors has become worse in the last decade (Carter et al., 2013). Although the reports do not separate incivility as a separate category for measurement, they do indicate an upward trend in negative behaviours in the workplace. In support of this survey, when discussing changes in the organisational culture, some participants mentioned the positive changes had occurred as a consequence of uncivil consultants leaving the organisation,

rather than the uncivil individuals actually changing,

Yeah I mean personally when I first started the consultants were the old school it was the guys who'd been here for years and we did things their way because that's what they told us to do, as things change you get new consultants in with new ideas a bit more of an approach as to they want the MDT's input and currently the lead consultant is a guy who started maybe five years ago now but from him starting we've had very close links with him and we've worked with him, moulded him to how we want that relationship to be with him (participant 10)

Finally, it was interesting to see how the workplace cultures of different consultants can sometimes clash and how challenging it can be for the Psychotherapists to deal with the resulting situation,

Yeah I think other people are quite careful around him cos the other thing is a lot of the consultants don't like to be called by their second name on our ward because we work so closely together so if you call mister (name removed) mister (name removed) he's like no it's (name removed) like you don't call me that and the same with quite a few of the other ones like mister (name removed) likes to be called (name removed) he doesn't want to be called mister (name removed) you know I guess it's cos they're trying to break down some of those barriers so we do all call them by their first name, if you call a consultant by their first name in front of this other consultant he will tell you off for it, so if you're discussing a patient and (name removed) said we could he'll say it's mister (name removed) and it's those kind of things that you have to be quite careful around (participant 16)

3.9.4 Power

The term of hierarchy and power were almost used interchangeably and always to direct negative attributions to those displaying uncivil behaviour. When discussing a situation, participants mentioned power both directly and indirectly, such as when challenging behaviour (see section 4.2.1). Despite power being described negatively, the resulting uncivil behaviour was always then justified (see section 4.2.4). For example, in the extract below, the pressures and stresses of the job were used as an excuse for displaying this power in a negative way,

Position of power, the hierarchy power, personalities definitely, do they employ people with certain sorts of personalities, you have to have a stiff upper lip and broad shoulders to be a division manager and a consultant I'd

have thought so because of the pressures and the demands of the job (participant 19).

When participants were discussing power and hierarchy, the discussion would often move to the topic of governance, as many described how being god-like and powerful in the hierarchy also meant consultants being untouchable and not answerable to anyone. Participants would often pose a question in the interview to develop this further, so ask if the consultant had a line manager or who conducts their appraisal? This is supported by Currie, Lockett, Finn, Martin & Waring (2009) as doctors can still do what they want without anyone above taking the responsibility for their actions,

I think sometimes consultants are thought to be on this pedestal and you can't challenge them to knock them because they are on this pedestal (participant 14)

Yeah I think there isn't anyone to challenge them, cos what they gonna say they're gonna say well sack me and there's no one you can replace these consultant aren't just ten a penny they know there's just them, they're untouchables in essence (participant 9)

These extracts highlight that those displaying negative behaviours cannot be challenged, supporting research that employees are reluctant to complain (Carter et al., 2013; Thompson & Catley, 2018). They believe the complaint will either not change anything or make matters worse; being untouchable was often provided as a justification for the behaviour and the occurrence of incivility.

These negative hierarchical beliefs about challenging incivility were identified as an issue within the Government Mid Staffordshire report (2013), recommending the establishment of a culture with openness, transparency and candour. In a follow up report, the Sir Robert Francis' Freedom to Speak Up review (2015), NHS staff felt unable to speak up, or felt they were not listened to. Further if staff did speak up, only 72% were confident it was safe to raise a concern.

3.10. Why they behave that way

Participants were asked the question why they thought the leaders or consultants behaved in the way they did. Similar explanations were offered. It was noticeable throughout the interviews that all the participants offered reasons for the uncivil behaviour, rather than just complaining. This theme of why they behave that way links to a number of other themes, such as hierarchy, patient care, workplace culture and challenging the behaviours. This section will examine why the participants thought the consultants behaved in an uncivil way, investigate the importance placed on specialist clinical skills, focus on classic style consultants, the lack of governance and the individual stress experienced.

3.10.1 Explain behaviour by various ways

It was apparent the participants had already thought about why the consultants behaved that way before they were asked in the interviews and this links to section 3.8, “what it feels like to work with these leaders”. The participants always offered some justification for the uncivil behaviour; this was a noticeable underlying characteristic of this theme. Participants commented they had to give an explanation to be able to cope with the incivility, for example, some suggested the consultants behaved in an uncivil manner as had a fear of being challenged, or lacked in confidence or were masking insecurities,

I sometimes wonder whether they're trying to hide a lack of whether it be knowledge or ability or you know lack of confidence in area almost trying to you know trying to hide if they are that sometimes, yeah (participant 11)

It's been challenging all along but it seems to have really come to a head and I think there's a lot of insecurities there that's his issue (participant 1)

As well as offering a reason for the behaviour, participants would also often discuss their feelings in the situation, such as feeling sad, often displaying empathy towards the consultant,

I think they are insecure and then they feel that they have to do it that way so that they don't they feel they won't get challenged as much but actually they get challenged more and it's sad really that they can't see that they could learn so much from other people and maybe if you talk to people they respect you more and not challenge you as much (participant 3)

The need to explain the behaviour may be further affected by the health professional context. Despite leaving work due to a consultant screaming, the participant below tries to rationalise the behaviour that seems to be shaped by the instinctive caring nature of the profession, demonstrated when the participant wonders if the consultant needed a hug,

I'm curious to know that do they just need a hug before I start talking to them, what do they need do I need to hold their hand as I'm talking I don't know, not that I could but (laughs) maybe someone next to them to hold their hand (participant 8)

The role of empathy in health professionals has recently been of growing interest within Physiotherapy as those clinicians who display empathy are rated more highly by patients (Opie & Parkes, 2015); the researcher is not aware of any research examining empathy towards uncivil individuals, that may be something more specific to those within the caring professions. There is also a gap in the literature examining how rationalising uncivil behaviour effects individual's ability to cope, so for instance, whether they are more susceptible to challenge the behaviour or to undertake another coping strategy.

In all the interviews, immediately after any derogatory comments were made about the uncivil consultants, an explanation was offered, suggesting the participant felt guilty. In the extracts below, one participant said the consultant had little man's

syndrome. Other words, such as idiot and arse were used, but no stronger phrases were used in any interview; significantly the individuals laughed after saying these comments implying, they were not serious. This was similar to the use of metaphors to describe uncivil individuals, as previously discussed (section 3.9.1),

Similarly sometimes when they're young they've got more to prove so he came in as a new consultant and had something to prove you know everyone best respect me and I'm gonna waltz onto the ward and expect everything to stop and the I guess maybe he's just an idiot and that's just the way he is (laughs) (participant 9)

Another common explanation offered for the incivility was poor social skills and many mentioned behaviours such as, consultants not being aware of their personal space or the lack of direct eye contact. Some participants commented on the consultant's shyness rather than saying they were rude, so rationalising the behaviour again,

I actually think that this individual is socially possibly fairly shy and so I think has managed to or has to resort to these behaviours sometimes because they don't have the confidence and the social skills to be able to relate to people in other ways so they become more directive and more dictatorial (participant 6)

Well one of them is quite a newly qualified consultant and I don't know whether he's trying to sort of stamp out his territory and with the other one I just think he has difficulty controlling his temper do you know, I think he finds it difficult to have a one on one conversation you know he doesn't make eye contact with you or anything like that he's very difficult to speak to (participant 17)

Other participants suggested reasons for the uncivil behaviour stemmed from the consultant's childhood, highlighting how behaviour is excused through labelling and diagnosing (Levine, 2003). Explanations ranged from suggestions of abuse, or being bullied as a child to their current home life lacking in some way,

I'm not a psychotherapist but probably a psychotherapist would say oh well deep in their past they were abused as a child or something and its led them

to be, or maybe they are just an arse you know what I mean maybe they are (participant 5)

I've thought about her so my assumptions about her behaviour at work are because her home life must be very different (laughs) she obviously perhaps she's not heard at home so that's why she just talks all the time at work and just thinking the role at home is perhaps very different to the role at work so that's why she tells people perhaps she doesn't feel respected at home and that's what she's clamouring after at work so I think all sorts of things to try and justify it (participant 8)

Another common cause often cited for the uncivil behaviour was blaming external factors; in these circumstances the nature of the consultant's role, with the pressure of patient waiting lists and a constant demand to free up hospital bed spaces,

there's probably a lot of external influences making them display that behaviour it's not that that is their personality. Actually I'm much more respectful of people's behaviours because there is often a trigger behind it (participant 20)

as far as I'm concerned a consultant is there to make that decision and ultimately the buck stops with them so dominance and occasional disrespect you can kind of understand in their role (participant 10)

Although many different reasons were offered, there was always an explanation given for the incivility of the consultant's behaviour. Incivility can represent a challenge on an individual's status by feeling undervalued (Porath and Pearson, 2010) so perhaps such justifications help to protect the Physiotherapists professional demeanour, allowing individual pride to be maintained through strategic deference to the consultant (Lively, 2000). This justification can be viewed as a way of protection, so reducing the negative consequences for the individual (Shaw et al., 2003).

3.10.2 Excuse behaviours as clinical expertise

A specific justification often given, was excusing the uncivil behaviour because of a consultants' clinical skills, or their specialised training, so again attributing incivility to another factor, rather than blaming the individual,

I think he's very proud of being a consultant which is fair enough he's worked very hard to get there and he is a very specialist consultant so you know fair enough really but I think that's why he doesn't say hello I think he's probably quite a stressed person I think he probably gets quite stressed about things I think that maybe why he gets frustrated at times (participant 14)

It's more one type cos the ones that do concentrate on the brain side of it are very different from the ones who do the spines as well because the ones who do the brains they tend to deal with people with brain tumours and things like that and I think they're more cos when they go into like neurosurgery they kind of go in two ways and you have, if you're dealing with people with brain tumours you have to be good at communication don't you and you have to be able to speak to their family, whereas with the spines it's more like chopping people up and sorting their backs out and you don't have to deal with compassionate side of it as much so maybe it's the two different cos it is more of the spinal ones that are the aggressive ones I think (participant 17)

In the extracts above, the participants felt that having these specialist skills was a justifiable reason for the consultant's range of uncivil behaviours, including the inability to even say hello, as well as not being compassionate in their role.

Another frequently used rationale for the behaviour of the consultants, was attributed to where they worked. For example, if they worked predominantly in theatre, then this uncivil behaviour was seen as justified, as a legitimate part of their role. Certain specialities are more likely to display uncivil behaviour and be more aggressive in their communication, such as radiology, general surgery, cardiology and neurosurgery (Bradley et al., 2015). This explanation, was then applied to the ward situation, and seen as a rational excuse for uncivil behaviour in the multi-disciplinary team (MDT) scenario,

I think it does have reflect maybe where you work a lot of the time, in saying that I'm thinking of some of the surgeons compared to some of the medics and the surgeons come across as more abrasive sometimes I don't know whether that's because in theatre you know hand me this hand me that sort of thing whereas the medics have to do more of a discussion (participant 2)

again that day to day stuff with the clinical side of life the consultants obviously being consultants are a lot more sort of try to be domineering and it's an interesting situation for them they come onto the wards to see their patients once a week when they're doing their theatre list they need to get their side of things across very quickly very concisely and that comes across as quite domineering and this is the way it must go (participant 9)

The above extracts emphasise the importance that the Physiotherapists place on clinical skills; when the consultant is viewed as a specialist, then their incivility is rationalised as justifiable. Youngson and Flin, (2010) stress how medical importance is placed on clinical and technical precision rather than cognitive and social skills; subsequently a lower significance is attributed to any leadership or communication skills (Flin, 2010).

3.10.3 Classic style consultant

Another common explanation for the behaviour was the general way the consultants had been trained and then learnt the role once in the workplace.

Well I suppose it's possibly their training I guess if they worked with an old school consultant that treats people that way I suppose they learnt from their mentor (participant 9)

It is once they start talking I must admit I start trying to reflect on oh you've made me feel like this and oh, and then I try not to be I try not to wind myself up cos then you start thinking well I wonder why you're like that so yeah I think all sorts of things as to whether any of them are appropriate or not as I was saying before to the consultant part of me thinks that's your, that's the way you were styled that's the way you were taught that's what I have seen consultants treat registrars as something nasty on the shoe and that's what you do and that's how you get on in the medical world so of this individual I think that's how you were groomed and that's how you were brought up and that's how you deliver it cos it is very much old school (participant 8)

The uncivil behaviour was also often attributed to the wider medical profession and how the workplace culture had shaped and influenced these classic style consultants, with their uncivil behaviour (Salin, 2003),

I think a lot of it is personality and the culture that they've been brought up with you know in a lot of cultures doctors are sort of the be all and end all aren't they and sort of put up on a pedestal (participant 16)

As above, the uncivil behaviour displayed by the consultants is excused and justified in reference to the culture of the workplace and through socialisation (Salin et al., 2014). A further consideration, that explains how negative behaviours continue through generations of professionals, is professional socialism (Lempp & Seale, 2004; McCloskey, Brown, Haughey & O'Hare, 2019) and professional identity and the establishment of a medical hierarchy within the different professionals within the workplace (Weaver et al., 2011).

3.10.4 Lack of governance

A reoccurring subtheme was the lack of governance and accountability of the consultant; many participants would compare this to the clear lines of structure within their own Physiotherapy department,

I think it depends on what leader you have and how you are led within the team, I think particularly within physiotherapy I think we know that we've got a structure and we know who to report to and we know who to go to with certain problems, people are allocated certain senior managers within physiotherapy and each one of those has specific roles so if we had a problem with a specific thing I'd know who to go to about that specific thing, I think we're better in terms of that when you look at physiotherapy as a and then go into like the wider like the ward based setting that's a little bit more chaotic and people, because of the turnover and the amount of staff there is I think that that's a little bit more chaotic than our team cos they tend to have, we don't particularly have a high turnover of staff and staff tend to stay for a little bit of time but on the ward it's just a massive turnover and people get confused with who's doing what there's no clear delegation of leadership I don't feel on the ward (participant 2)

I think it's very different between disciplines, massively different in fact I think probably more from a consultant point of view I think it potentially lacks it

there's no clear lines of accountability as such, where I think more in the physiotherapy department we've got clear lines of leadership, accountability, things like that (participant 14)

As identified in section 3.9.2 on being god like and untouchable, the lack of governance was also seen as a rational for the behaviour, and again seen as justifiable as part of the workplace culture, described below as the territory,

Well at consultant level I think there's very little kind of governance on that because they're here to do that job and it is part of the territory sometimes (participant 9)

I wonder if it was clearer what we needed to do to manage the consultants in a more structured way I wonder whether anybody would but it's all a bit woolly I don't think anybody fully understands who manages them (participant 4)

The lack of structure and governance further strengthens the prevailing power structures with such power cited in the literature as one of the most frequent reasons for uncivil behaviour (Cortina et al., 2001; Klingberg et al., 2018).

3.10.5 Stress

Many participants mentioned the stress of external pressures as a reason for the uncivil behaviour, with examples such as targets, lack of time and the ongoing bed shortages,

And then I think the other doctor I think sometimes there's just lack of time and they just they don't wanna take the time to listen to anybody else cos they just wanna get on with, there's so much pressure to get people out of hospital that it's not about what's best for the patient anymore it's about how quick can we get them out of the hospital so if you're trying to say oh well I need a bit more time it's quicker to send everybody to a home and if they think that's where they'll ultimately go anyway, so I think yeah lack of time and pressure of work has got a lot to do with it (participant 7)

It's about squares moving around the board and if the squares don't move that's a problem for them and they're gonna get they're gonna have issues so they need to keep the squares moving (participant 18)

The stress of the role with many external pressures and stressors was often discussed throughout the interviews as a rationale for the uncivil behaviour; as supported in the literature, the occurrence of incivility increases with higher stress levels (Roberts et al., 2011). Such pressures can mean there is no time to be nice at work (Pearson & Porath, 2005), as illustrated in the extract below, where the behaviour and temper of the consultant are excused through the life and death demands of the role,

Well I think the other thing is to do the job that they do they probably do have to be a bit odd, that's the wrong way of saying it but you know the decisions they have to make are life and death on the table you know and the things that they see I think sometimes their stress levels must be quite high to deal with it, I don't know how they do the job that they do so perhaps some of that the moods that they get is dealing with the job and perhaps you can't you know, you know who fly off the handle cos there's quite a few of the surgeons who are very like have quite bad tempers but perhaps it attracts that type of personality maybe like the high risk side of things. (participant 17)

As identified in the literature review, the external pressure of highly stressful environments, constant changes, challenging and difficult work can cause or contribute to the negative behaviours (Hunt & Marini, 2012; Owens et al., 2019; Quine, 2001).

3.11 Patient care

The theme of patient care was noticeable throughout the interviews, despite no direct question being asked about patients or the care they receive. The patients were always of paramount importance, as the Physiotherapists would relate how examples or situations of incivility had affected the patients. This was apparent with both direct and indirect behaviour, such as how their teams behaved around the consultant, or the consultant's behaviour.

3.11.1 Impact of the consultant on the ward

This theme illustrated how uncivil behaviour was linked to patients in various ways,

for instance, through the consultants' communication or bedside manner. As previously identified above (section 3.8.1), the consultant's moods and lack of consistent behaviour detrimentally affected the care of the patient,

Yeah there's a couple that are quite difficult but there's one and I think it's the same that he seems like he's interested in the surgery and you know he enjoys that side of it but when it comes to actually talking about the patient it's quite difficult and his temper and his mood is very unpredictable (participant 17)

I have had short conversations with him about various different patients on the ward and it really depends what mood he's in which again to me it's a really poor quality of a leader slash consultant cos to me they're the same thing I personally think they're the same thing, and I think that regardless of what kind of mood you're in that day you still have you know a job to do (participant 1)

These extracts indicate how patients can be indirectly affected by the behaviour of the consultant, as their unpredictability influences discussions about patient care. The impact of the consultant's presence on the ward was also discussed by many participants, and how the atmosphere changes, which in some examples was then directly associated with potential mistakes,

I think they feel I think people feel like they always need to keep busy they can't look like they're not doing anything, I think there's more potential to make mistakes because they're uptight, and it just changes the atmosphere on the ward or in the clinic environment cos you're always on edge as to what's gonna be asked of you (participant 2)

he's made people cry because he loses his temper and he ran them over with a drugs trolley cos they were in the way and he didn't he did it in temper but he didn't do it deliberately to run them over he just wanted to get through and just shoved and bashed in, and he gets like if there's any noise in the room while he's doing his ward round he'll get very angry about that even if you were actually there before him and we had a case where the patient was deaf and the therapist was behind curtains he was hard of hearing so the patient kept shouting what do you want me to do and they were saying sssshh sssshh because he was on the round and he came round the curtain and said can you be quiet I'm on my ward round and so it wasn't the therapists fault the therapist was really upset about it (participant 7)

These examples above illustrate that the consultant is on the ward, priority is given to their behaviour, resulting in staff feeling tense and on edge, so ultimately affecting patient care. In the last example, the ward had to be silent, even to the point of telling a patient to be quiet, as the participants seem scared of how the consultant may act. The consultant's earlier behaviour of pushing a drugs trolley and making staff cry is described in quite a rational, almost excusable way, as the consultant demanded silence on his ward rounds. As far as the researcher is aware, the impact of uncivil consultants upon the ward situation or within MDT's has not been studied, and in particular how the consultant's behaviour and presence on the ward effects patient care. To date, the focus has been examining incivility in nursing and surgery (Riskin et al., 2015; Youngson & Flin, 2010).

Another example of how patient care was indirectly affected, concerned staff behaviour changing in response to uncivil consultants being on the ward; as discussed (section 3.8.4) participants would spend additional time in preparation for discussions as they anticipated these would be difficult; some staff reported hiding out of the consultants way,

I could see a difference in how my team behaved around that individual yeah, people got very defensive people avoided spending time on the ward and found little pockets to hide in to write notes rather than being present so that impacted directly patient care cos in my team we need to be flexible and we need to be able to drop something to be able to go and help someone else out and if people aren't present then that impacts to some degree (participant 10)

could get quite aggressive at times and that really does affect your performance cos you feel like you're on guard all the time and the more you're like that the more mistakes you make and it's like a vicious circle that you're on edge all the time (participant 17)

In these extracts, the presence of the consultants impacted communication concerning patients and also directly affected patient care, increasing the likelihood of making mistakes.

The relationship of the consultant with the patient was also a frequent area of discussion (section 3.8.7) when a consultant had patient communication skills, it was always observed and described as a bonus,

He's not someone I hear much about as to what he's particularly like with the patients but to be honest quite a lot of them are bad with the patients anyway (participant 9)

The apparent low importance placed on consultant's social skills was evident throughout the interviews. Particularly in the last extract, poor behaviour was accepted as the norm, and such incivility can therefore become normalised (Andersson & Pearson, 1999). In these extracts, communication is assumed to be a desirable attribute, rather than regarded as an important and acquired clinical skill (Youngson & Flin, 2010).

Another aspect of patient care was discussed by one participant, who not only saw a general degradation in patient standards, but also stressed less care surrounding the dignity of the patient. To the researcher's best knowledge this is not examined in the incivility literature,

Things were happening in front of patients but then I think as soon as you see your leader doing things in front of patients or saying things in the wrong environment then instantly that makes it that makes it acceptable for the rest of the team to do such a thing so I think there were standards dropped in a lot of ways, not in clinical care or safety or things like that I think in that sort of dignity perhaps in terms of patients hearing things they shouldn't be hearing (participant 10)

3.11.2 Role of mediator between consultant and patient

As a consequence of the consultant's lack of social skills (see section 3.10.1) participants often reported adopting a mediating or explaining role, positioning themselves between the patients and the consultant,

they just give orders no sort of rationale as to why they want that particular thing doing, quite abrupt and not got a very good sort of bedside manner

with, which is particularly important with patients and you're left explaining to the patient afterwards what they've then said to the patient, it creates like quite a bad atmosphere on the ward everybody's sort of tensing up tight when that person enters the ward (participant 2)

I think they get blinkered and it's like yes that's a knee I'm gonna sort that knee out and they forget the knee's actually to the person at the end of the bed and cos they've got such short times and things like that especially if they're on the ward in an acute setting it's a case of well I need to sort that knee out and they'll maybe speak to the patient afterwards. So many times you see the consultant going in, the consultant goes out, you go to do your treatment and the person will say so what is it they're doing and you'll then explain it to them, and that happens all the time, all the time (participant 9)

To the researcher's best knowledge, this role of mediation is not apparent in any of the studies of uncivil behaviour and a notable area for future research. Such research would understand the intervention of professionals in the role of mediator and the impact it has on patient care, as well as the individual impact on the Psychotherapist.

they see him as their saviour but he's a pain who leaves other people to mop up after he's been on a ward round (participant 4)

A rationale for this uncivil behaviour, was often attributed to the pressure of the job and how many of the consultants were almost unaware of the patients as individuals, seeing them as more part of a routine or a process,

Cos they're under pressure, they're under pressure from and they've again I feel often they've lost sight of what is actually in front of them rather than it just being numbers on paper (participant 18)

The literature identifies how attention has changed to focusing on processes rather than people within the NHS, with a strong emphasis on productivity in a transactional climate (Parry & Proctor-Thomson, 2002). The focus on lack of resources and freeing up beds identifies a change in focus for management, particularly apparent in the nursing literature (Brown, 2016). Many participants brought up the issues about the challenge of bed numbers, patient care and the

tension that brings, and in support of the literature such pressures were seen as a reason or justification for uncivil behaviour (Youngson & Flin, 2010).

3.11.3 Patient care with examples of good consultants and leadership

Patient care was always discussed during examples of good consultant behaviour or leadership. Participants would highlight consultants who cared or were concerned about the patients, as it seemed different to the norm,

And you know that he really cares about the patients as well, you can tell sometimes he's quite affected by things that have happened on the ward or you know some of the things that he does you think that's beyond what you needed to do whereas some of the others they do the surgery they hand the patients over and that's it (participant 17)

The person that I work with that's an AH consultant at the minute I've only been working with him since January so it's a relatively short sort of space of time, he's excellent with his patients which is lovely to see and his sort of bedside manner as such is fantastic and he's not governed by timescales if somebody wants to come in and offload war and peace to him in essence he will listen and respond and the patient actually feels like they've had a good service and been listened to and they've had a chance and I think that's quite, cos I've previously worked with different consultants who are very much a, b, c, out but he gives the patient that opportunity you can definitely see the patients value that (participant 14)

Other examples of how consultants positively contributed to patient care was notable through respect for the Physiotherapist's roles. This was demonstrated when consultants gave the Physiotherapists more autonomy and asked for their opinion when treating the patient. Similar to all areas in the interview, the participant would always prioritise the patient; rather than highlighting the respect of the consultant or how pleasant they were, they would always ultimately stress how such positive behaviour benefited the patient,

some are very happy to take other people's opinion and I think that's where going back to a good leader model he's an excellent communicator and he really is open to sort of taking opinion, understanding it and he won't just listen and then make a call not caring about what we've been talking about he will really clearly take it into account, and ultimately we understand he is the leader of that patients care about the teams care and whatever decision

is made for the right reasons but yeah I think the fact that we worked on building that relationship with him as a new consultant into the Trust and that's gradually just blossomed into where we are now and him being the lead consultant is excellent cos we've got his ear (participant 10)

These examples are in contrast to earlier extracts of poor patient care associated with incivility (section 3.11.1) with the extremes of civil and uncivil behaviour representing quite different experiences and standards of patient care (Kaiser, 2017).

3.11.4 Incivility when the physiotherapist is not present

The issue of patient care was also apparent, even when the Physiotherapists were not present at the time of the uncivil behaviour. Several examples were discussed concerning the impact of the consultant when the participants were not present and how this had negatively impacted them, and their professional pride. In the extract below, the consultant had made promises on the Physiotherapist's behalf and there were other similar examples of commitments given to patients when no Physiotherapist was present, with often the consultant not informing them of the commitment given. Many discussed how this displayed a lack of professional courtesy, with one example resulting in an official patient complaint against the Physiotherapist,

This particular consultant tends to come onto the ward at like five o'clock on a Friday when the majority of sort of health care professionals involved okay the nurses are there but a lot of kind of other people aren't there, often the family aren't there, all the allied health professionals aren't there, social work if they need to do anything aren't there, the doctors are usually kind of going off shift at that point, he will often come onto the ward and not tell anyone he's coming onto the ward, go and break bad news to a patient or say things to a patient and then leave and no one even knows he's been there apart from a few things that he's scribbled in the notes, and that's happened on multiple occasions and I think that that to me is a really poor example of not only how you treat your patients but how you treat your other staff because every other consultant that I know comes onto the ward and at least makes his presence known to at least give people the opportunity to you know at least give the nursing staff an opportunity to go with them so that they know what's been said it's not about what they're going to say necessarily it's about

knowing what decisions are going to be made, and one of the frustrations that I have personally is this said consultant has made promises to patients and to families about the input that they're going to receive from physio without consultant to myself, so I don't know about it so they admit patients for intensive rehab for a week which isn't something our service can provide for example but doesn't have the professional courtesy to come and have a conversation with me and say this patients struggling I think if we can admit them just for a week we're going to do x, y and z medically is there any possibility you could make this patient a priority just for this week let's see if we can improve things if we can't then we can make a decision towards the end of the week it might just be that they need a bit of boosting. That I wouldn't have a problem with and I would go out of my way to try and fulfil that because a week or two is doable, or I can say to the consultant I'm really sorry but I've got someone off sick and I've got someone on annual leave for the next two weeks I'm going to struggle to meet that, but what he does is he makes promises without but on other people's behalf which I just think is really poor practice and I think it's very disrespectful (participant 13)

The literature concentrates on direct incidents and impacts after uncivil events, but the researcher is unaware of any studies examining the more indirect effects of uncivil behaviour, (as in the extract above) when the Physiotherapist was not present, so highlighting a gap in the research.

3.12 Workplace culture and culture of leadership

This theme focused on the relationship between leadership and culture and was evident, either directly through questions about leadership, or indirectly in examples about situations the participants introduced. This section will examine changes within the management culture, the relationship between the leader and the culture, bullying and teamwork.

3.12.1 Previous management culture and resulting strategies

When participants discussed leadership and the culture in the workplace, they would often revert to the past and mention changes in the Trust,

I think things have changed I think quite drastically with the push for staff satisfaction surveys being filled out the Trust as a whole are looking for a lot more opinion on how we're running certainly from the last CQC visit the whole culture of bullying and that has been stamped on, and I think there has

been a massive change with the leadership of the Trust as a whole (participant 10)

I don't think it's as common as it used to be, I definitely can see I've seen a change over time with the way leadership is viewed, I think there is a hierarchical system but I think people are much more willing to maybe challenge and question what people are doing higher up or management, and I think there is more of a push for more team working rather than just you know being seen as you know you have you're an autonomous practitioner and we will take on board what you're saying. I don't think there's many consultants like that now but they're the ones you tend to remember (participant 3)

A common way of measuring changes in culture (see section 3.9.3) was how uncivil consultants were less prevalent than in previous years. This simultaneously highlighted other positive changes, such as practitioners being more autonomous and feeling more able to challenge authority. Participants mentioned other changes in the workplace culture regarding improvements of their role, so when working in MDT's or their clinical scope and practice as a Physiotherapist. When discussing these changes, the participants would always then relate it to how they were accepted or welcomed by the consultant,

Oh yeah, so most of them now and I think the thing is physio has changed and we've extended our scope into different practices that's I'm sure challenged some of the old school consultants it's like oh look physio can't do part of my job, but if you get a good consultant they realise how invaluable we are cos we save them so much time by doing some of their work for them (participant 9)

Within my setting within the physio department I think we've got a great leader who disseminates well to the level below, I think because I've worked in the Trust for a long time I've seen a lot of changes within the leadership styles with different managers who have come and subsequently left and I think it's improved for the better, I think it's less hierarchical than it was seventeen years ago and I think we're much more involved with the vision of the service that we previously were. I think within the context of consultants I think the same I think it's improved for the better I think we're more seen on a level than we were when I first qualified (participant 20)

This change in Physiotherapy practice and culture was highlighted by the

Chartered Society of Physiotherapists (2017) as the main theme at their annual conference and identified how the profession is maturing and emerging from its teenage years.

3.12.2 Relationship between leadership and culture of the workplace

The strong relationship between leadership and culture of the workplace was constantly acknowledged throughout the interviews. When management structures or cultures were discussed, it was always seen as an improvement on the past and this was apparent when participants were discussing the trusts in general or the culture,

Broadly I think it's much, I think it's all about personality I think there's a pretty stringent hierarchy and I think the really, really high leadership for example the Chief Executive you can tell that there's a much, much better culture now that the Chief Exec's changed and I think that's filtered down to a large extent (participant 4)

I hate to use the word but that there was a bit of a bullying culture that we could give a number of very good reasons why we couldn't do something but then would just be told well get on with it or we'll do it to you, so that's hard to work with and very hard to engage with somebody who reacts like that but I think now we've been able to influence and alter those behaviours and we see glimpses every now and then of what was but I think because they aren't, I think we've kind of toppled that power differential now (participant 6)

The culture of the organisation is related to the behaviour of the leader and the influence of such senior leadership on the wider organisation culture (Krapfl & Kruja, 2015; Omari & Paull, 2013) and this relationship was often discussed in the interviews,

I would say it's changed significantly over the last couple of years, my direct leadership is fantastic because of the level of communication it's quite inspirational it's very open and because that's my immediate leadership that's kind of what I'm most aware of cos that influences my day to day, that I've felt has been previously squashed I assume has been squashed from previous management strategies where it would be if we were in a room can we shut the windows just in case anybody's walking past outside (participant 8)

In contrast to all other examples given and as identified above, the leadership and culture within the Physiotherapy department was always praised. Participants would discuss the positive influence of the Physiotherapy leadership on workplace culture, particularly regarding open communication. As highlighted in the literature, there is an increasing emphasis on the impact of leadership on workplace incivility, as individuals follow the behaviour cues of those leaders (Clark & Ritter, 2018). The example of the Physiotherapy leadership can be seen as additionally supportive, by moderating the relationship between incivility and employee wellbeing through motivating employees (Arnold & Walsh, 2015) and making them feel valued (Beattie & Griffin, 2014; Miner et al., 2012).

3.12.3 Leaders clinically good – yet not good at other leadership

When discussing leadership in regard to consultants, the participants always discussed consultant's clinical skills, with many not mentioning other aspects of leadership, such as their communication skills or teamwork,

Yes, I mean obviously specifically for the consultant or any clinical specialist excellent knowledge, background knowledge, theoretical knowledge, practical skills in that particular area is what you'd hope for and expect (participant 11)

It was almost as if such social skills did not count as a part of their leadership role, yet in contrast, when discussing the physiotherapy leader, this communication and teamwork aspect was viewed as essential. The contrast between leaders was stark. Although participants often mentioned the importance of people skills for consultants, it was almost seen as an extra and something that was desired but not essential (see section 3.8.7). When participants discussed the leadership qualities of the consultants, it was clear that uncivil behaviour did reduce the participants view of the consultant's overall capability,

Again I suppose good clinical knowledge but then being able to speak to people so you can be fantastic clinically but if you can't communicate to the patient and to the rest of your MDT then you could be the best doctor in the world but people won't have that confidence in you and that affects how the patient then reacts they react to that don't they and so do family and the MDT (participant 14)

I understand he's a good surgeon but I've really lost respect for him recently and I think the ward rounds have just got that ridiculous at times that I just and he'll there's been a couple of snidey comments made to me not directly aggressive or anything like that but they've got an underlying get this patient out of here they're your responsibility but he hadn't you know he didn't understand the background of why they were in and you know how much work we'd put into it and I just thought how rude you know all you're worried about is your bed days and you want to get people out you're not worried about the patient and I just thought I actually have no respect for you cos to me you're in a caring profession you're there to look after your patients and if all you're worried about is your numbers (participant 17).

Despite incivility being often rationalised by participants, these extracts also demonstrate their frustrations at how it affected patient care, yet as previously identified (section 3.10.1) these behaviours are then attributed to the culture of the organisation, so an accepted way the consultants behave (Salin et al., 2014).

3.12.4 Bullying

Although no questions were asked about bullying, the word was often mentioned and particularly so when referring to historical events. Only when the participants directly used the word bullying was it coded into this theme, which is in support of the literature as the behaviour of bullying is more overt, so targets are more likely to interpret them as intentional. (Andersson & Pearson, 1999; Schilpzand et al., 2016). Bullying was often mentioned as part of the previous culture within the NHS trust as discussed within these following extracts,

you know that is a bullying attitude which obviously the Trust is trying to get rid of, they've got rid of a few big bullies and it's I think they've still got a little way to go (participant 19)

Hmm it's interesting cos I was thinking about this when I was thinking through prior to coming in today, I think people that have that approach sometimes do end up being admired because they're seen as strong even though they're really difficult to work with so I know that this individual was quite well thought of within the organisation which was quite frustrating for us at the time and continues to do so I think he's one of the few people who's still in the post that he was in when an awful lot of them were moved on because of the bullying culture (participant 6)

One participant mentioned how a person left the hospital after challenging someone for their uncivil behaviour, and in telling this story, they emphasised how this acts as a warning for others to keep quiet in similar situations,

I suppose it depends on your experiences I mean we saw with the individual I mentioned we saw they were very powerful and got a member of staff sacked for doing just that (participant 17)

As well as the above situational example, participants also mentioned the previous bullying culture, and often hinted that the culture today still has bullying elements. By way of an example, bullying awareness training has occurred at lower levels within the Trust, but participants commented it was needed higher up the organisation as well. Some participants emphasised the ironic situation that the champion for reducing bullying within the Trust was actually known for being a bit of a bully,

No she didn't, no, but they did say it was a bit of a tongue in cheek moment when they appointed her as the bullying tsar but you know she's got quite a reputation of being a bit of a bully (participant 19)

In addition to examples where the actual word bullying was used, there were other situations that discussed or described bullying behaviour. In the example below the participant discusses the Physiotherapy on call, that is a service only to be used for respiratory problems,

So like we have a late service till eight pm and if there's patients in A&E that need discharging after that time and we're not here they'll ring the on call physio's which are just for chest problems respiratory problems but if it's just

a mobility and A&E that they want to get home they'll ring them on the on call mobile several times at home it's like management will ring and say you have to come in and see this patient I will ring (name removed) and tell them that you're refusing to come in and they'll use language which makes you feel under a lot of pressure to do what you know you shouldn't be doing (participant 18)

3.12.5 Teamwork

The theme of teamwork often occurred but is covered by many other sections and themes; the main focus of effective teams was communication and in particular, how a disrespectful leader can destroy that communication, such as in MDT's,

I think on the whole we have more consultants that you can approach and chat to and that will come to you to ask your opinion than other Trusts that I've been on placement or worked in which is why I like working here, cos yeah I've worked on stroke, the three consultants again on there it's very social, MDT is quite you know it can be intense at times when you're discussing patients but generally you know there was a baby shower the other day and one of the stroke consultants was there one of the physio's (participant 16)

...it's just different peoples style of working isn't the same as yours and it's acknowledging that isn't it cos the team I work in particularly in the MDT setting have massively different ways of working to me but actually we all complement each other and because of that that's why it's a great team because we all work in a very different way (participant 20)

These extracts indicate the importance of teamwork within the Trusts, and particularly within MDTs and the different medical professions. Team working within health, has a strong relationship with both performance and staff attitudes (Richer, Dawson & West, 2011), although as identified throughout this chapter, such interprofessional teams may also experience tension, hostility, and some barriers to knowledge sharing (Mitchell, Parker & Giles, 2011).

3.13 Chapter summary and links to the next chapter

This qualitative study aimed to examine the following research questions:

- Does uncivil leadership exist and to what extent is it part of the workplace culture?
- What effects does uncivil leadership have on the individual?

Through examining the key themes from the data, the research questions have been answered and identify how uncivil leadership, whilst improved from the previous workplace culture, does still exist within the Trust. Participants made references to the past throughout the interviews, with examples involving old-style consultants or a bullying culture, but these were often used as a measure and means of expressing improvement. However, there were also many examples of incivility that demonstrate it does still exist and is part of the everyday culture.

Uncivil leadership was associated with consultants and any positive examples of leadership stemmed from the Physiotherapy department, or a few selected and noteworthy consultants. The effects of incivility on the individual and the team were numerous, from avoidance, to rumination and anxiety and to reducing patient care discussions. The behaviour of the uncivil consultants was often rationalised, either as an internal justification, such as their childhood background or personality, or was blamed on the pressure of the external environment, through targets and stress levels. As a means of protection from the consultant, the Physiotherapist would often act on behalf of the team to ask any questions that were needed, this is worthy of further research. The influence of the consultant on the ward and within MDT was an area that would benefit from further study, particularly regarding the effects of incivility on the patient and the Physiotherapist.

At all times and throughout every theme, the patient was paramount, and this was apparent when for instance, discussing the autonomy of the Physiotherapist or the clinical skills of the consultants. The consultants' clinical skills were always cited as the most important aspect of their role and distinct from their social skills. The

latter skills were seen as additional aspects. As highlighted in this chapter, this had implications for incivility and these clinical specialist skills provided an ongoing rationale for the uncivil behaviour.

The findings from these themes highlight the need to examine what the participants actively do in such uncivil situations, for example, whether they challenge or undertake other coping strategies. These areas will be explored in the next chapter.

Chapter 4 Study 1 B – Challenging and not challenging

4.1 Chapter overview

This chapter follows on from the data collection and analysis examined in chapter 3, by focusing on the process of challenging incivility. As discussed in section 3.2, the focus of this qualitative study was to explore uncivil leadership in Physiotherapy, to determine if it did exist, and if so, to then identify from the narratives the key themes that emerged. These themes would then form the basis of developing and delivering an organisational intervention. This chapter will focus on how the participants would like to challenge the uncivil leadership behaviour, so to inform the design of the intervention in study two. The following two research questions are answered by concentrating on the individual and what strategies they use and to what result.

- What strategies do individuals utilise when experiencing such uncivil behaviour in the workplace?
- Do individuals challenge uncivil behaviour and to what results?

As reported in chapter 3, participants readily described consultants they worked with who displayed incivility in the workplace. This incivility resulted in a detrimental impact on individual aspects such as motivation, self-esteem, as well as impacting the atmosphere on the ward, communication and ultimately patient care. As reported in previous studies, individuals are frequently unwilling to intervene during such events (Hershcovis et al., 2017), preferring instead to avoid the uncivil individual. Within the data there were some indications as to why this might be the case. Consultants were viewed as untouchable (see section 3.9.2), with participants using words to describe them, such as god-like and highlighting the lack of governance and management structures (section 3.9.4). Other reasons focused on the culture of the workplace and the prevailing hierarchy, that reinforced

such uncivil behaviours (see section 3.12.2). However, despite these reasons, participants consistently described steps taken to challenge the behaviours and reported on the perceived effectiveness of their different approaches. Subsequently, the theme of challenging such uncivil behaviours and its sub themes are discussed in this chapter.

Challenging the uncivil behaviour was evident throughout the interviews and the participants describe reasons why behaviour was not challenged, the results when challenged and how they would like to challenge. It was noteworthy that all participants could easily recall an incident or example where they had experienced uncivil behaviour, that they felt needed to be challenged. The participants described different responses; this is consistent with previous literature (Folkman & Moskowitz, 2004; Hershcovis et al., 2017) identifying that targets and witnesses to incivility react in different ways, that can be both effective and noneffective.

4.2 Challenging the behaviours

4.2.1 Feeling disrespectful to challenge

Most often participants said the main reason for not challenging behaviour was the seniority of the consultant. This is consistent with the other themes reported around hierarchy and power (see section 3.9.4),

I think there's a hierarchy isn't there within the hospital and you've got you sort of respect those at a more senior level than yourself and you tend to not question or not question as much those that are a more senior level than yourself and I think that person's also got a lot of experience of however many years, well about thirty forty years which is a lot isn't it which is more than obviously what I've got so I think experience and knowledge and clinical banding is probably why (participant 2)

As identified in the extract, the participant felt it would be disrespectful to challenge the behaviour, due to the consultant's experience, clinical knowledge and their seniority in the Trust. When describing the behaviour, the individuals commented

they could not challenge the consultants, using words such as, inappropriate, as in section 3.10.2. This is consistent with findings that status inequalities are reinforced by the way individuals tend to respond to uncivil behaviours, and likely to base their responses on the consequences of resisting or challenging the behaviour (Porath et al., 2008). In support of the literature, lower status employees try to maintain their professional demeanour and pay deference to the higher status individual, known as strategic deference (Lively, 2000).

4.2.2 Not appropriate to challenge

Another justification for not challenging the uncivil behaviour was the comparison between the present and past culture, and the improvements over the years. Examples of the past culture would often be discussed, such as, how the consultants would only drink out of china cups and used to ignore the Physiotherapists. One particular example was how the Physiotherapists had to ask the nurse for permission to even talk to a consultant,

I remember when I first started working here you know the consultants still all wore white coats and you know you didn't dare go and disturb a consultant my god you'd be eaten up and chewed out and spat through the door, whereas now...(participant 9)

Many commented that as the current behaviours were such an improvement, it was not appropriate to challenge, almost implying they should be grateful for these changes regardless of the incivility. Another similar reason given, was that uncivil consultants were now only in the minority, demonstrating a positive change and a further justification for not challenging,

I think if everybody acted like that it would be awful but the fact of the matter is it's one person out of a large team that we work with that all treat me as I should be treated so to be honest it doesn't really affect me but I think if everybody acted like that it would make me feel awful, you would think that nobody respects you nobody likes you but as I say because it's just one person you just think well, yeah (participant 16)

There were often many examples given of previous consultant's behaviour, and the individual would relate them to their own experiences to further justify not challenging the behaviour. Such organisational stories are transferred both formally and also informally through the processes of socialisation and internalisation (Walter, Van Jaarsveld & Skarlicki, 2014; Whyte & Classen, 2012) and the individual adds their own experiences to these stories, to refine and develop their own knowledge (Janson & McQueen, 2007; Swap, Leonard, Shields, & Abrams, 2001). These stories also relate to the team's shared values, norms and beliefs, and influence how the team communicate (Levi, 2017).

4.2.3 Not challenge as just deal with it

Participants often mentioned that because incivility had been allowed for so long, then it would be difficult to deal with now anyway, as it had become an acceptable way to behave and part of the culture,

Yeah I think I'm, I think because I've been qualified for so long now I think I just accept it to be a hazard of the job (laughs) (participant 19)

I think probably usually we've given permission for that behaviour to happen so that's probably gone on for years and then it's, I don't know I think that cos we've allowed it to happen then it's almost like you know oh we've allowed it to happen all this time I don't know why we don't deal with it but some people do I mean I know that some members of staff they would probably question that but I don't (participant 15)

This extends the notion of formalised hierarchy and management structures being a barrier (Thompson & Catley, 2018) and how culturally derived expectations of what is or not appropriate in the workplace, also influences whether the behaviour will be challenged. The culture of the workplace was often discussed by participants and how established through processes, such as socialisation in the clinical environment (De Swardt et al., 2017) making uncivil behaviour part of the norm. This is further strengthened with the development of professional identity

(Weaver et al., 2011) as well as the hidden curriculum (Phillips & Clarke, 2012; Wilkinson, 2016) apparent throughout the different medical professions.

Another reason for not challenging, was the lack of governance in place to manage the consultants, with many participants commenting on the lack of a management reporting structure (see section 3.10.4). Such responses support The Freedom to Speak Up Report (2015) that identified how staff felt unable to speak up, or if they did, they felt they were not listened to. Participants disclosed how they saw it as difficult to challenge the uncivil behaviour, as the consultants seemed almost beyond being challenged,

I could have a tantrum too yeah they can get away with things when you're consultants that's just the way it is (participant 7)

4.2.4 Justification of the uncivil behaviour so not worth challenging

During the interviews, when participants described an incident or an example of uncivil behaviour, they also often offered a reason for not challenging it. This was discussed in chapter 3 under the theme “why the consultants behaved that way”, as explanations for uncivil behaviour were always provided. These reasons and justifications for the behaviour focused both on internal reasons, (such as the consultant's personality or social skills) to more external factors, such as the culture, stress and pressure of the NHS (see section 3.10.5). Participants used these reasons as an explanation for not challenging the behaviour and discussed how they had therefore learnt to live with incivility,

he's had a lot of people working with him, he's never changed in that time and that's his personality and you just I think he's kind of beyond change now, but yeah I feel we really need to keep that open so sometimes I do bite my tongue think just let it lie there's no point even going there (participant 17)

As identified in the above extract, participants would provide reasons for the consultant's uncivil behaviour, with the conclusion that it was not worth challenging.

In this extract it is unclear whether the participant felt the incivility was not worth challenging because the consultant's personality was fixed, or whether they were resigned to the fact that challenging the behaviour would not affect any change.

The behaviour of the consultants was often justified by their clinical skills, with comments such as, a particular consultant was one of the best surgeons in the country and extremely specialised (see section 3.12.3). This was always provided as a reason why the consultants could behave how they wanted, and why they should not be challenged. This clinical specialism justification was apparent when discussing uncivil behaviour directed at patients, as well as Physiotherapy staff,

Yeah I think there isn't anyone to challenge them cos what they gonna say they're gonna say well sack me and there's no one you can replace these consultants aren't just ten a penny they know there's just them they're untouchables in essence (participant 9)

There's lots of headshaking when he walks away because we all know what he's like but we've all worked with him for a long time and there's an awful lot of what was all that about but I don't think anyone behaves particularly differently but he does leave a bit of a wake of ill feeling and a change in atmosphere behind him certainly, and that takes it a while to sort of explain to the patients that he's a busy man and...he's a good surgeon (participant 12).

In support of the literature, incivility is linked to status and medical hierarchy (Pearson & Porath, 2005) and consultants described their own seniority acting as a protection against rudeness towards them (Bradley et al., 2015).

4.2.5 Not have the energy or skills to challenge

Another reason for not challenging was the pressure of the Physiotherapists' daily working lives, with many commenting about their lack of emotional energy and time to engage in challenging the behaviour. This is supported in the literature, as incivility produces higher levels of emotional exhaustion (Connolly, 2017), so making additional tasks difficult. Instead, of investing in the time to challenge face

to face, the participants discussed how they developed coping strategies to avoid the person, often using emails rather than having a conversation,

He answers his email and you can be quite direct and get the answer that you want whereas sometimes you go in and you go to see him and if he's in a bad mood you think I need to ask him this and this but by the time you've realised that he's in a bad mood you've perhaps forgotten some of the questions you wanted to ask and him and you come out thinking oh I missed that opportunity whereas in an email you can clear your head can't you, you can focus on what information you want (participant 17)

Not having the appropriate skills to engage in these challenging conversations was also often discussed, and many participants would say that as work was so pressurised, they did not have the time or energy to engage in what would be a difficult and unfamiliar process for them,

I guess it depends on the person who the consultant or the leader is being rude to, some people are probably not confident so it may be that they're at a stage in their career where they feel that they don't have the necessary skills and knowledge to challenge (participant 19)

As identified above, participants commented on the lack of skills and knowledge to challenge the individual, that often resulted in avoidance coping strategies. In support of the literature, avoidance techniques did not seem to remove the negative emotion associated with incivility, as it is associated with greater emotional exhaustion, enacted incivility and less forgiveness (Hershcovis et al., 2017).

4.2.6 Challenging on behalf of their team and others

A critical determining factor as to why a participant did challenge incivility concerned the target of the uncivil behaviour, so specifically whether it was directed towards them as an individual, or towards their team. If any uncivil behaviour involved their team, participants would always challenge the consultant, as team identity was important within this interprofessional environment (Mitchell et al.,

2011). It was almost as though a line had been crossed, that prevented them from considering any other course of action,

Because there's this hierarchy isn't there and you don't, yeah, you can't sort of, although I did once with a consultant who was, one of my assistants was working with a set of notes and he came and basically just sort of snatched the notes from where she was working with them and disappeared with them and she was really cross about it and because she was my one of my staff I felt like I had to address it, had it been me I probably would have just let it go but because it was someone that I you know I felt like I had to go and challenge him (participant 5)

Watch out for that one, yeah but I just tend to keep it if you've got any concerns or problems with people then make sure you come and find me (participant 19)

Participants acting on behalf of their team was a consistent factor that seemed unquestionable and non-debatable. The words of protecting were often used, as well as commenting it was part of their role to look after their team,

He's very keen to blame when things go wrong when quite blatantly it's got nothing to do with my team and quite often I've had conversations with him where I've said do you know I really sincerely wish that if you had an issue you would come to me with it rather than shouting at a band five in the corridor in front of the patient please don't do that anymore because you know we can have this conversation behind closed doors but can you explain to me you know what your issue was on that particular day and he'll just wave his hand in my face and say I really don't want to discuss this (participant 4)

Yeah I certainly challenged her, my team challenged her through me, I wouldn't of wanted any of my team to challenge her directly that's I think that's my role and I'm there buffer I think in that regard, did the nursing team challenge her? They bitched a lot whether they actually challenged her I don't know (participant 10)

When discussing their teams and challenging behaviour, participants would often mention examples of rotational band 5 staff. These are newly qualified Physiotherapists who change their role and specialism every 6 months to gain experience and knowledge. The theme of protecting these new Physiotherapists from uncivil individuals was strong throughout the interviews, and in total contrast to nursing studies on eating our young (Meissner, 1986) where a culture of bullying

rather than supporting trainee nurses was prevalent. Within the interviews, participants would warn their band 5 staff not to discuss various physiotherapy treatments with certain consultants and to accept what they say, but when the consultant was not on duty, they could revert back to their preferred treatment. This change in clinical practice and not being able to discuss treatments was often recalled by participants, and further identified how uncivil behaviour can have a direct impact on patient care,

Yeah you feel like you have to protect your colleagues from this kind of undermining that goes on cos we get rotational staff that come through every six months and the environment is very difficult for them it's just a difficult clinical environment but as well as that having someone challenge you from day one about what you know (participant 10).

Well I try to prepare them for it at induction because I think that's only fair because I think if they were completely unprepared for some of the things that he does they'd be absolutely horrified and they'd think there was something that they'd done personally so I think it's only fair for me to prepare them, so they are prepared as well as I can do but it's still not very nice especially some of our quieter team members (participant 4)

Within medical studies, leaders discuss protecting their teams, using metaphors such as holding up an umbrella and filtering out the noise for their team (Gipp, 2016); these extracts emphasise the team's culture, and how shared values, norms and beliefs will influence how the team behave, communicate and perform (Levi, 2017). In support of the literature, intervening in situations in the workplace when involving aggression or discrimination (Pouwels, Van Noorden, Caravita, 2019) requires prosocial behaviour and professional moral courage (Sekerka, Bagozzi & Charnigo, 2009). This act of moral courage may explain why Physiotherapists challenge uncivil behaviour when directed towards one of their team, as they see it as a moral situation.

Alternatively, this response could also be seen as part of their leadership role, and different leadership theories explain this behaviour, for instance, authentic

leadership acts in a way that is honest and transparent, so challenging the uncivil behaviour on an ethical stance (Jeanes, 2019). Whereas, such a challenge could also be seen as defending the cohesiveness of the team, with functional leadership to facilitate group interaction (Fleishman et al., 1991) so applying a solution to work problems. Another reason is explained through instrumental leadership as it examines the internal and external environment, with a strategic focus on task and teams, so defending any external behaviours that are destructive to this (Antonakis & House, 2014).

4.2.7 Challenging on behalf of consultant

The extent to which the participants were willing to challenge on behalf of others, was also apparent in examples where consultants were being uncivil towards other consultants. This uncivil behaviour was then challenged by the Physiotherapists. Based on the earlier themes of hierarchy and power, this behaviour would not have been anticipated, yet it seems that the individuals had an over-riding concern to protect their team and others, so influencing their drive and confidence to challenge,

I think they have been better since and as far as the bullying I actually emailed the other two consultants and said you know this is uncomfortable in ward rounds in meetings because it's obvious the disagreement between you three and it's not professional, and it did get better after that, they didn't think they did anything wrong (participant 7)

This confidence to challenge was not so apparent when the uncivil behaviour was directed towards them as individuals. The contrast was stark. Instead of challenging on behalf of themselves, they would offer a justification for the uncivil behaviour, so often letting the incivility go unchallenged.

4.2.8 Challenging on behalf of their profession and professional pride

Another area where the participants were more inclined to challenge, was when

the profession of Physiotherapy was questioned or doubted by consultants. This was described in a different way to a personal challenge; it was noticeable that when the individual felt the uncivil behaviour was directed to their team or their profession, they were prepared to challenge more,

Maybe because of the position he's in but I think people are challenging him more I think people realise that it isn't just against them, I think when you realise it's not just against one profession or one person people are more prepared to challenge because they don't feel it is just themselves or whether you know he doesn't like me (participant 3)

Lack of respect for the Physiotherapy profession was often given as an example of uncivil behaviour, and many participants frequently mentioned pride in their profession. In particular, this was regarding their specialism and Physiotherapy expertise, such as working on the neuro or spine ward, or within the intensive care unit (ICU). When discussing respect, many would give examples of the consultant not including them in discussions relating to Physiotherapy, even when they were standing next to them, or not referring to them by name despite having worked with them for many years,

They were the two main things that really bothered me, also being fifteen feet away from this person and they would start having a discussion about physiotherapy but not involve the physiotherapist stood right there, you think if you wanna have a really constructive conversation include us in that conversation, do you want me to just flounce over and say oh here I am at your beck and call or do you want to say oh can we discuss this now or whatever am I just to hear oh he's talking about me should I get involved? (participant 1)

Other examples included the consultant not turning to face them, so the Physiotherapist would have to talk to them sideways without any direct eye contact,

you know sometimes you feel like a small child that's pushing into a queue you know it's that kind of you know, because actually if you stand there people are just going to step in front of you so you have to kind of nudge your way in and say actually and then he's not somebody who will have a conversation like this I often have conversations with the side of his face (participant 13)

Many participants discussed the difference of opinion and lack of consistency between various consultants. This was particularly apparent when discussing clinical decisions and the Physiotherapists felt frustration at not being able to challenge such opinions. Examples were given of consultants stopping conversations, by holding up their hand, saying they were not interested to immediately stop further discussion,

...like you're not really valued as a clinician you're just there to do what they say basically which sometimes is fine but when you're all trained in your own profession you've all got your own clinical expertise but they're not willing to listen to your viewpoint it just makes you feel like well what's the point really (participant 2)

The strength of the participants professional identity, as in the above extract supports social identity theory (Burford, 2012; Tajfel & Turner, 1986, 2004) where the individuals have developed a sense of membership and belonging. Their professional identity, as a Physiotherapist, as well as their self-esteem, is bound up within this group membership, as it takes on an emotional significance (Hogg & Terry, 2000). The different professional identities within the NHS, develop and intensify during the lifespan of a career (Joffe & Mac-Kenzie-Davey, 2012) with socialisation (De Swardt et al., 2017) and professional identity (Weaver et al., 2011) and may explain the way other identities impact each other in daily working situations (Carrol & Levy, 2008).

4.2.9 Standing up to the leader – yet the behaviour stays the same or reverts back

When discussing examples of challenging uncivil behaviour there were mixed results as to how successful it had been. Many participants described attempting to have the challenging conversations, but the consultants either walked away, shouted or said they were too busy to engage in such a discussion,

I know he's had some people in tears cos then if they said anything to him he then shouted back at them and you know was really quite rude and things and you know he's had some of the girls in fits of tears and stuff (participant 9)

I was with a patient doing some work with a patient and he was an anaesthetist a consultant anaesthetist who had a list that day and he needed to come and see all his patients before he went into theatre and he just barged in, stood in front of me, started to talk to the patient, I was mid-sentence, the patient just looked at me cos you could see the patient was thinking who do I talk to what do I do who do I speak to, so I just said oh I'll come back later then and walked out of the room and then after he'd finished I thought I can't believe that that's just so rude I could feel myself thinking well it's just not on so I was like excuse me but can I have a word with you in the office, I don't know how old I was I was probably only in my twenties it was probably the first time I've ever challenged anybody, and I just said you know we've all got our things that we need to do with patients but I was actually mid-sentence when you walked in I said you know I understand you're time bound and if you'd come in and said excuse me but would you mind can I interrupt I just need to ask this patient a few questions I said that would have been fine but it's just you walked in and he just looked me and said I'm a very busy man I haven't got time for that and walked out (laughs) and I was standing there going okay (participant 12)

Other participants discussed examples of challenging the uncivil behaviour, yet the uncivil behaviour staying the same. This seemed to have a negative effect on their confidence in undertaking such conversations in the future. In examining the literature and the coping strategies of avoidance and confrontation, individuals who confronted the perpetrator were more likely to forgive (Cortina & Magley, 2009), so a step towards resolution, suggesting it is more of a long-term strategy, than avoidance coping. However, with regards to the reoccurrence of incivility, the coping strategies of both avoidance and confrontation were found to be ineffective. Being confrontational is a direct response and perhaps can be seen by the perpetrator as conflict, resulting in repeated uncivil behaviour.

Confrontation as a coping strategy despite not preventing incivility recurrence, provides the ability for the target to exert control. It also produces a cathartic effect,

by letting go of the negative emotion of stress and forgiving the perpetrator (Hershcovis et al., 2017).

I thought I was then even though it was a small thing and I said it and I got the answer I wanted and I felt quite floaty inside like oh yes I can do this and then something happened a bit later and I just went oh I'm back to small child again and I can't cope with this and I lost it, well I didn't lose it but I lost the ability to challenge (participant 8).

This section demonstrates examples of some of the behaviours the participants experienced when trying to challenge incivility. It reinforces the need for a training intervention to support individuals in the most effective way to challenge the uncivil behaviour.

4.2.10 Challenging the behaviour – positive results

Despite these examples, and in contrast to the prevailing body of research, there were examples provided of how the individual challenged the behaviour resulting in a positive outcome, with an improved future relationship. A factor that participants highlighted was how the positive change in culture had enabled them to have such successful conversations,

this particular individual just didn't want to listen they had their own preconception and nothing was going to change it and it took quite a lot of work and a huge change in culture in the organisation before that individual softened and became more receptive to what we had to say (participant 6)

Organisational culture has been widely reported as an enabling factor for incivility and workplace bullying, which has implications for challenging incivility, as there may need to be an assessment on the organisations readiness to seek to address incivility (Salin et al., 2014).

4.2.11 Challenging in a jokey way – yet successful

Challenging uncivil behaviour was often undertaken using humour and a jokey style, which many participants commented was the only way they knew how to

challenge. They also felt it had more chance of success, as did not undermine the consultant's status,

It was brilliant it was fine cos I kind of made it slightly jokey and I said I need a word with you and I took him in the office and I said one of my staff was very cross with you because you snatched the notes away while she was working on them and it was really quite rude, but I kind of said in a quite a light jokey manner and he took it really well he said did I my dear oh I'm so terribly sorry I didn't realise I had and I said well you did so just watch out you know kind of like that and that manner works really well with him (participant 5)

...so if you kind of make it a bit jokey they'll you know they take the points but you can't you can tell them off in a jokey way and they'll take the point but if you told them off in a serious way I'm sure they wouldn't appreciate that. I told one off for being on the phone in MDT but we did it in a jokey way and she laughed (participant 7)

The use of humour in this instance was used as an effective strategy in challenging uncivil behaviour. Research within humour examines how it is often used as a means to build cohesion and reduce conflict in teams (Ponton, et al., in press), yet the author is unaware of any studies focusing on the success of challenging incivility through humour.

4.2.12 How individual would like to challenge behaviour

Participants described how they would like to challenge uncivil behaviour, based on mutual respect, with a direct and honest conversation. As discussed previously (section 3.8.2), such open conversations with the consultants were rare, and often a source of anxiety for the Physiotherapists,

It would be great if they had the interpersonal skills to be able to get them to reflect on their behaviour so sometimes a direct challenge is like putting water on a fire a fat fire or something it just escalates it but to be able to use humour and to be able to come up with the right words that individual would perhaps take away and reflect on at a later stage would be a wonderful attribute to have (participant 6)

In an ideal world, well I don't mind the hierarchy but in an ideal world you wouldn't have to say everything you want to say in ten seconds because they

would give you time to listen and try and they would try and understand (participant 12)

Some participants had actually imagined having such a challenging conversation and had even worked through the differing scenarios, but did not have the confidence to actually start it,

that I feel that to challenge him about quite a major thing I think to myself that it could one of two things could happen he'll either turn to me and he'll say oh I'm really sorry in future I'll come and speak to you or, and which is what I fear will happen and is more likely to happen because that's the perception I've built up is that he'll turn round to me and he'll say well I'm the consultant and I make the decisions and you do what I ask you to do, even though he's not asking me to do it he's telling me to do it. So I've never had that confidence to be able to have that conversation with him and I've had various conversations with other professionals (13)

Many Physiotherapists had considered challenging the uncivil behaviour but avoided it, because of a lack of knowledge, skills and confidence. In support of the literature, poor experiences of communication are the biggest area of complaint within the NHS (Brighton et al., 2018). Training does occur, but difficult conversation interventions are mainly associated with knowledge and skills for effective patient communication (Health and Medicine, 2018), rather than staff interactions. This reinforces the need for interventions to increase Physiotherapists confidence in challenging conversations with staff and feeling sufficiently prepared to be able to initiate these conversations. The author is not aware of any studies assessing the confidence to have challenging conversations within Physiotherapy.

4.2.13 Chapter summary and links to the next chapter

Continuing from chapter 3, this qualitative study aimed to further examine the following research questions, by examining what participants actively do in uncivil situations and whether they challenge or undertake other coping strategies:

Does uncivil leadership exist and to what extent is it part of the workplace culture?

- What effects does uncivil leadership have on the individual?

The findings from this chapter highlight how participants act in such uncivil situations within the theme and subthemes of challenging the behaviours. Most example situations discussed by participants focused on why the behaviour was not challenged, which included reasons of hierarchy and status, being seen as inappropriate and justifications through internal and external factors. Other reasons given were both the formal governance and informal organisational structures, such as socialisation and the changing culture of the workplace.

When participants did challenge the behaviour, acting on behalf of their team was always undebatable, and this would appear to override any feelings of lack of confidence. Challenging incivility when directed towards the Physiotherapy profession was also a strong drive; this professional identity and pride meant participants were inclined to challenge more. When uncivil situations were challenged with unsuccessful results, this had a negative effect on confidence and reduced the individual's intentions to challenge in the future. This identifies the need for skills development within this area. Lastly, the participant's discussed ways they would like to challenge and again highlighted the need for more skills in difficult conversations, which to date have mainly focused on patient communication.

The next chapter will discuss the design and delivery of an organisational intervention to address these findings in study one, with the aim of increasing knowledge, skills and confidence to engage in challenge conversations

Chapter 5: Intervention Development

5.1 Chapter overview

Based on the findings from the original 360 leadership development programme and the 20 physiotherapy interviews, the next stage of the Professional Doctorate was to create an intervention to give AHPs increased confidence and self-belief in managing situations with uncivil people. The thematic analysis of semi-structured interviews in the previous chapter, identified how an intervention needs to examine different strategies and coping techniques. These range from directly challenging the uncivil individual, to learning to live with the behaviour through techniques such as, reframing, team support or developing personal resilience (see chapter 4). Building on these findings, this chapter will describe the steps taken in developing an intervention to address these needs.

5.2 Organisational interventions

Organisational interventions have inconsistent and varied results, particularly within the areas of employee health and well-being (Nielson & Randall, 2013) with most studies focusing on the underlying reasons why work affects well-being, rather than the design, implementation and evaluation of the actual intervention (Briner & Rousseau, 2011). Interventions often fail as they present the organisational problems in a vague manner (Briner & Walshe, 2015) or the aspect of wellbeing is dispositional (Diener, Oishi & Lucas, 2003). Other reasons for failure, include being unrelated to changes in people's external environments or resources (Diener, Lucas & Scollon, 2006) or they may only respond to individual based interventions (Semmer, 2006). To counteract such problems, the intervention in this study adopted an evidence-based approach, (section 5.6) starting with a thorough analysis of the problem, as well as ensuring the

intervention was designed for both practitioners and researchers, highlighting its practical significance (Briner & Walshe, 2015).

The elements that both hinder and facilitate the success of the desired outcomes of any intervention, can be grouped into three themes (von Thiele Schwarz, Nielsen, Stenfors-Hayes, & Hasson, 2017). These are the intervention design and implementation, the context of the intervention and participants' mental models of both the intervention and their work situation (Nielsen & Abildgaard, 2013). A useful framework that has been widely adopted uses the realist evaluation approach and is particularly suitable for the health care setting (Marchal, van Belle, van Olmen, Hoeree & Kegels, 2012). Realist evaluation examines the context of an intervention, the mechanism and the outcome, which is called the context-mechanism-outcome (CMO) configuration (Pawson & Tilley, 1997). There is always an interaction between the context and the mechanism, and this interaction creates the intervention outcomes (Wong, Greenhalgh, Westhorp & Pawson, 2012). The realist viewpoint examines exactly how an intervention brings about change (Pawson & Tilley, 1997).

The context of an intervention consists of situational opportunities, as well as constraints, and are often not fully recognised or appreciated by researchers (Johns, 2006). In this study the context, and constraints, such as the operational pressures and demands of an NHS Trust was fundamentally important. The intervention needed to fit this context to achieve the desired outcome, so examining what works for who and in what circumstances (Nielsen & Miraglia, 2017), as outlined in the section below.

5.3 Context of a clinical setting

As based in a clinical environment, this intervention would need to consider the practicalities of an acute and pressurised NHS hospital setting, which has different

demands to many other organisations. A typical NHS hospital is operationally unsustainable, as demands and activity are continually increasing (Owens, et al., 2019). Furthermore, this situation seems untenable with rising admissions and growing delays in discharging patients, combined with a slowdown in government funding (West, 2016). The combination of these reasons account for the severe financial and operational pressures that many participants discussed when referring to the growing demands of patient waiting lists, and the crisis of shortage of beds (see section 3.10.5).

Within the NHS Trust undertaking this research study, the situation of staff recruitment and retention was particularly a problem, but due to anonymity reasons, cannot be discussed in detail. Instead, the overall national problem can be examined, as the latest NHS official figures in 2019 identified extreme levels of vacancies for AHPs and nurses (NHS digital, 2019) with over 100,000 NHS staff vacancies in total, which is equivalent to 1 in 11 of all NHS posts. In addition, there are very high levels of staff turnover, as well as chronically high levels of sickness absence and presenteeism.

A consequence of this operationally demanding context was the difficulty of releasing staff to attend training, and this was a constant issue for the Clinical Lead. Based on such demands, it was decided to maximise attendance by designing a short intervention workshop. The timing of the workshop was also important, as needed to avoid key operational peaks, so for instance, the winter pressure months, busy clinic days such as Mondays and shift handover times. The workshops were also to be delivered on site at the hospitals, to minimise travel time away from clinical appointments and patient demands.

5.4 Considering organisational sensitivities

From previous experience and knowledge of delivering professional development within this NHS Trust, the researcher was aware of potential organisational sensitivities in designing workshops about uncivil leadership. To highlight a problem with some of the leadership, could lead to negative internal stories and external press releases. This was particularly sensitive within this NHS Trust, as a few years before, there had been a problem of bullying at a senior leadership level, which had been leaked to the press and led to some staff dismissals. However, this pattern of bullying is not unique and identifiable in many other NHS Trusts across the country (Carter et al., 2013). Subsequently, although still important, it would have been organisationally naive and inappropriate to blatantly highlight leadership incivility as a problem again. As identified in section 3.12.4, many participants referred to the positive changes from the previous bullying culture, and how the leadership had improved, as highlighted in the extract below,

certainly from the last CQC visit the whole culture of bullying and that has been stamped on, and I think there has been a massive change with the leadership of the Trust as a whole (participant 10)

It was important for the workshop to build on these organisational improvements, and realist evaluation identifies how interventions cannot operate in a vacuum, so an interplay between context and certain mechanisms (Greenhalgh et al., 2015). The workshop therefore needed to contribute to this changing culture by considering such organisational characteristics (Wilkinson, Hinchliffe, Hough & Chang, 2012), so supporting the individual's skill development, rather than destructively highlighting the problem of leadership incivility.

5.5 Scoping meeting to design the intervention workshop

At the scoping meeting the above reasons were all discussed, and the Clinical Lead requested the intervention workshop needed to be about gaining confidence in challenging conversations, rather than advertising there was a problem with uncivil leadership. In consultation, it was decided that focusing on challenging conversations to understand the principles and techniques involved, but then highlighting the issue of leadership incivility within the content of the workshop, would bypass such potential organisational problems.

With this aspect in mind, it was decided the workshop should be titled “How to have challenging conversations”, rather than refer to leadership in the title. As outlined in chapter 3 during the interviews, even though the consultants were the main profession being uncivil to the Physiotherapists, focusing solely on this staff group could be problematic, as uncivil behaviour was likely to exist in other areas and at all levels.

The Clinical Lead also highlighted that as so difficult to release staff from clinical practice for training, it would be more cost effective for the workshop to cover a wider focus of challenging conversations, so benefitting her team in a myriad of ways. Despite these additional elements, the workshop still incorporated the findings from the interviews, which was to gain skills and confidence, as the central mechanism of the intervention,

Some people are probably not confident so it may be that they're at a stage in their career where they feel that they don't have the necessary skills and knowledge to challenge (participant 19)

It would be great if they had the interpersonal skills to be able to get them to reflect on their behaviour so sometimes a direct challenge is like putting water on a fire a fat fire or something it just escalates it but to be able to use humour and to be able to come up with the right words that individual would perhaps take away and reflect on at a later stage would be a wonderful attribute to have (participant 6)

Therefore, the aim of the workshop was to improve the overall skills and confidence in having challenging conversations, so enabling the Physiotherapists to deal with uncivil behaviour from senior consultants.

5.6 Importance of being evidence-based within healthcare

As evidence-based practice has been widely implemented in different health related areas (Kamath & Guyatt, 2016) and a major policy driver in healthcare systems (Rosser, 2016; Wallace & Vanhook, 2015), the workshop needed to align with this focus. Although the concepts of being evidence-based are highly valued, with examples such as, improved patient care and flow in the emergency department (Popovich, Boyd, Dachenhaus & Kusler, 2012) there are still challenges to its widespread adoption (Rosser, 2015). For example, within the profession of Physiotherapy, many cite lack of time and resources as being a barrier to practicing evidence-based techniques day to day (Silva, Da Cunha, Garcia, & Costa (2015). Although the intentions and applications of evidence-based practice seem to be mismatched, it is important that this intervention aligns with the current era of medical practice (Armstrong, 2017; Rosen, Ruzek & Karlin, 2017).

A further reason was to develop an evidence-based practice intervention within organisational research and Occupational Psychology. It is relatively undeveloped within these fields, so has much to learn from interventions in medically evidence-based practice (Briner & Rousseau, 2011: Rousseau, 2006).

5.7 Workshop content selection

As the interviews had involved a personal commitment from the Physiotherapists, as well as incurring time away from clinical practice, the researcher felt a

responsibility to create the most relevant and effective workshop. This also aligns with the BPS code of conduct and professional and ethical responsibilities.

To design this workshop, many different techniques and training programmes were examined to find the most suitable content. Such examples included reviewing popular business books, including titles such as, "Fierce Conversations: Achieving success in work and in life, one conversation at a time" (Scott, 2002) which was based only on the author's experience and personal knowledge, so not suitable for this evidence-based study. Another business book "The Asshole Survival Guide: How to Deal with People Who Treat You Like Dirt" (Sutton, 2017) claims his techniques are shaped by scholarly research, yet on further reading the scholarly research was from google scholar and only used to identify the extent of such "asshole" leaders. The actual technique again is only drawn from personal experience and knowledge.

Changing the focus to search in a more academic field, the work of Crawshaw (2007) and her Boss Whisperer programme was examined. This technique is based on psychoanalytic theory and centres around the abrasive leader. The researcher had previously attended a training course run by Crawshaw to become an accredited Boss Whisperer, to see if the techniques could be used for this study. However, as it focused on having regular one to one coaching with the leader, it was operationally unrealistic, and also did not address the confidence issues of the participants in the interviews. The researcher was also unaware of any evaluation undertaken to examine the effectiveness of this technique, so an example of an intervention that is regularly used but lacking in evidence-based practice (Briner & Rousseau, 2011). For these reasons, it was considered unsuitable for this doctorate. It was difficult to find a technique for the basis of the workshop that was evidence-based, credible, simple yet effective. To further aid the search, an

opportunity arose through the researcher's work to become an accredited ACAS workplace mediator, as discussed in chapter 7. This course was fundamental to the development of the intervention workshop, as the mediation technique of ACAS was based on having difficult conversations and followed a clear, simple structure that would be ideal for the intervention workshop.

5.8 Harvard University's conflict management training programme

Subsequently, similar to the techniques of ACAS, the book of "Difficult conversations: How to discuss what matters most" by Stone et al., (1999) was chosen as the basis of the workshop. This approach has an evidence base to support its use, as well as being Harvard University's preferred conflict management training programme in their Law School. The evidence for the techniques used within this approach are based on cognitive therapy (Beck, 1991; Hofmann, Asmundson & Beck, 2011) research on cognitive distortions (Gellatly & Beck, 2016), and looking at mind over mood (Greenberger, 2016). The programme also draws on the theoretical framework of the power of authenticity and listening (Bosch & Taris, 2014; Rogers, 2003) and established theories of social psychology, such as group dynamics (Tajfel, 1982). The Harvard programme was suitable for this study, as the programme was applied, professionally respected and based on over 15 years of applied research at the Harvard Law and Business School. Further applied research has been conducted on the intervention programme, adding to its evidence base. Within the field of healthcare, Cochran, Charlton, Reed, Thurber & Fisher (2018) identified the value of incorporating Harvard's conflict management training in medical education, and Martin et al., (2015) identified the importance of clinician's recognition and management of emotions during difficult healthcare conversations. Identifying and managing your

emotions is one of the key elements of the Harvard's conflict management training technique.

5.9 Transfer of training

The overall aim of the intervention workshop was for the participants to apply the challenging conversations technique back to the workplace, and so consideration was given to factors affecting the transfer of training and the transfer process (Baldwin & Ford, 1988; Tonhauser & Buker, 2016). These form part of the contextual factors used within the realist evaluation approach. The transfer of training is a constant concern and challenge for organisations (Zumrah & Boyle, 2015) as in one study, 62% of employees used their new knowledge after training, and this fell to 44% after 6 months and finally to 34% after a year (Saks & Belcourt, 2006). The transfer of training was important in this study and in particular, it focused on individual factors, training design factors and the work environment factors (Kirwan & Birchall, 2006) as discussed in the sections below.

5.9.1 Individual factors

The individuals' self-efficacy (Parker, 2000), their expectations (Magjuka, Baldwin & Loher, 1994) as well as their motivation (Kirwan & Birchall, 2006) are factors affecting how learning is undertaken and then transferred back to the workplace (Foss & Pirozzolo, 2017). These individual factors had been discussed in the interviews, as well as in the pre workshop literature. The aims and expectations of the workshop had been clearly set, both in the invitation email for participants, as well as in the introductory section of the workshop. All 20 interviewees had discussed negative experiences of uncivil behaviour and resulting individual consequences, so it was hoped they would be motivated to learn about this technique and improve their situation. Self-efficacy was frequently mentioned within the interviews; therefore, this was to be an important measure within

intervention workshop. The participants confidence in challenging a conversation was varied, as they identified it depended on the subject and individual involved, and whether the conversation concerned themselves, their team or their Physiotherapy profession (see section 4.2.6).

Organisational commitment (Tesluk, Farr, Mathieu & Vance, 1995) and job involvement (Noe & Schmitt, 1986) were factors that seemed high in all the interviews, although this question was not asked as part of the interview schedule. The participants were all incredibly proud of being a Physiotherapist and working in the Hospital Trust, as well as for the NHS in general. Despite some of the difficulties they discussed, such as lack of resources and operational pressures, none of them mentioned wanting to leave their jobs or dissatisfaction with their roles. These factors would assist in the successful transfer of the training (Foss & Pirozzolo, 2017).

5.9.2 Training design factors

With regards to research and recommendations for the training design, these had to be considered within the limitations of the pressured clinical situation. The use of goal setting (Brown, Latham & Sexton, 2000; Smither, London, Flautt, Vargas & Kucine, 2003; Thach, 2002) was incorporated as the participants worked on their own example throughout the workshop, with the goal of having their challenging conversation after the session. The participants were also asked to anticipate how to deal with potential difficulties (Burke & Baldwin, 1999; Richman-Hirsch, 2001) and this was a key area to be reconsidered in the post workshop two months later.

5.9.3 Work environment

Following any workshop or training intervention, when the participants are back in the workplace, various environmental factors can affect the transfer of their training

(Zumrah & Boyle, 2015) These factors can either inhibit or facilitate the process, such as peer support (Ng & Ahman, 2018) or perceived organisational support (Zumrah & Boyle, 2015). The workshop was designed to incorporate processes to facilitate this transfer, such as highlighting the importance of colleague and peer support (Chiabura & Marinova, 2005). This focus on support was incorporated into the workshop, as participants were encouraged to work together on their example if it was appropriate, after considering confidentiality aspects. The researcher emphasised the role of continuing to support each other after the workshop, such as in the preparation of future challenging conversations or in a debriefing role. As many worked within the same department, support and encouragement for each other was stressed as key parts of the process.

Prior to the workshop the researcher and the Clinical Lead discussed the importance of supervisory support back in the workplace, as a work climate factor to facilitate the transfer of knowledge (Cromwell & Kolb, 2004). Measures were put into place to debrief all line managers in the department so they could offer their support, as well as the majority attending the workshop. This was hoped to be key to the effective transfer of training. The opportunity to apply the training (Kirwan & Birchall, 2006) was also an important factor to effective transfer. In conjunction with the Clinical Lead, this was developed into the model with the follow up workshops, by encouraging participants to have a challenging conversation in between the two workshops sessions.

5.10 Piloting the intervention - mechanism of change

A pilot study is a necessary step in the research process, and the results can inform decisions regarding the intervention delivery, the contextual factors and also the implementation (Donald, 2018). Within this study, the researcher undertook an individual trial of the challenging conversation process, as outlined in Harvard's

conflict management training and Stone's (1999) book. This was applied to two challenging conversations - a personal and a work-related issue, with successful results for both examples. This success was determined by both situations involving an in-depth challenging conversation with a positive outcome. For this initial pilot study, the technique chosen was identical to the book and no changes were made. The researcher wanted to personally test this process to increase the familiarity for an effective delivery, as well as gain some useful experience and examples for developing the intervention workshop.

5.11 Pilot workshop

A further pilot workshop was delivered and although the challenging conversation step by step technique used in Stone's (1999) book was kept the same, other aspects were included to incorporate the knowledge generated from study one (chapters 3 and 4). As it was important to consider the transfer back into the workplace, the background context to the workshop was added, as well as an overview of some of the content from study one regarding uncivil leadership. This was particularly important as many of the participants in the intervention would not have been involved in the interviews in study one. To ensure the workshop was designed from the findings of the qualitative interviews, additional areas were included in the content, such as a facilitated discussion on having challenging conversations with those in senior leadership positions. The researcher also designed a section on coping strategies, such as, when the person refuses to have a conversation or when the conversations are not successful, as these were key themes emerging in the interviews (section 4.2.9). Research from learned optimism (Seligman, 2006) as well as practical and interesting current examples on resilience were added, such as quotes from Michelle Obama's autobiography. This area of coping strategies and how to have challenging conversations with

those in senior positions were not part of the Harvard Law School's workshop or Stone's (1999) book, so an additional focus, based on the findings from the qualitative research in study one.

This initial workshop was piloted in June 2018 with a team of four participants at the researcher's workplace. Following the feedback from the participants and the researcher's reflections, various changes were made. It was apparent that the workshop was information heavy and far too theoretical. It lacked a main case study example that could be developed through all the different five stages of the technique, as well as shorter practical examples throughout the workshop, to add clarification through all the stages. Following this pilot, the final version of the workshop was shorter and more applied, with various case studies and examples to aid understanding.

5.12 The finalised workshop design

The final workshop was designed around Stone's (1999) book and the Harvard conflict management technique, but in addition incorporated the findings from study one, such as the different coping strategies and dealing with senior colleagues, as discussed above. This Harvard technique for challenging conversations is based around a five-step process, but to try and enable the transfer of this knowledge back to the workplace, a key aspect was for participants to actively engage in their own example. The participants were asked to think of a difficult conversation they would like to have, with the goal of having the skills and knowledge to have this conversation by the end of the workshop.

To further assist the transfer of knowledge, a follow up workshop was to be designed two months afterwards, to review the challenging conversations and to share successes, as well as address any concerns or gaps in knowledge. The follow up workshop was to be flexible to allow for the researcher's reflections and

the participants feedback to be incorporated into the design. However, due to timings of the delivery and organisational demands on the NHS Trust, only two follow up workshops were delivered, and so not included in this evaluation.

5.13 Intervention workshop content

The workshop followed a set structure (see PowerPoint slides in Appendix K) which first consisted of a facilitated discussion about what a challenging conversation is and why we need to have them. The participants were then asked to think of a challenging conversation that had gone well, and one that had gone badly and what was the difference. This was then discussed as a group, with volunteers giving their examples and the session being facilitated by the researcher. The participants were then given time to think of a challenging conversation they would like to have, which they could develop as an example throughout the workshop. The end goal was to have this conversation as soon as possible after the workshop finished.

The learning outcomes of the day were presented, with an introductory section on why having challenging conversations is necessary, and why they often go wrong. The Harvard technique, with its five-step process was then introduced, with participants slowly taken through each stage. To facilitate learning an overall case study was developed through each stage, as well as many smaller examples to further illustrate each area. The participants also continued to develop their own example at each stage, with plenty of time being allowed for discussion with each other, as well as the researcher interactively walking round the group to offer help, advice and support.

The workshop also covered what to do if the conversation was not successful, or if the other party refused to engage in the discussion. Various reframing techniques, as well as studies and research on learned optimism (Seligman, 2006)

and other coping techniques, such as humour (Kuiper, 2016) were discussed, with volunteers providing everyday examples to illustrate the usefulness of the techniques. This was a group facilitated session, so the participants could learn from each other, as well as offer peer support and encouragement to aid the transfer of learning.

During the final stages of the workshop the participants practiced their opening line of the challenging conversation with the person next to them, or in groups, again to increase confidence. They were also encouraged to work out the structure of the conversation, so felt more prepared. The workshop concluded with an overview of all the stages and allowed time for questions. The researcher stayed behind in the room after the close of the workshop to allow time for individual questions, and those participants that wanted to discuss confidential situations. Individuals stayed on average 30 minutes after the end of every workshop. At all times the researcher ensured the atmosphere was relaxed, and they were approachable, interactive and encouraged discussion.

5.14 Reflective evaluation of the workshop

It became apparent that the researcher's confidence and experience grew as the workshops continued, and with reflection this may have impacted their effectiveness. For instance, the researcher provided more relevant clinical examples as the workshops progressed. This may have affected the experience, as well as the understanding and transfer of knowledge back to the workplace. One example given in the group discussions was how a member of a participant's team would often come into work late, not apologise and then get a coffee before starting work. This simple example was so often acknowledged by others as being a common issue, so became a standard example in all later sessions.

As the sessions continued, the researcher also became aware of key points in the workshop where participants needed more guidance, so progressively learnt when to be proactive and offer examples to further explain the process. In the first few sessions this did not occur, which may reflect that the researcher was lacking in experience of delivering this workshop. Whereas, in the workshops near the end of the programme, the researcher learnt how to anticipate these points and what examples could be used to help clarify the process.

At the beginning of each of the workshops, all participants were asked to think of an example of a challenging conversation they would like to have. This example was then developed throughout the workshop, with the aim of having the skills, knowledge and confidence to have this conversation immediately after the workshop had finished. However, after a few sessions, it became apparent that often during the workshop, some participants would change their example, as realised a previous conversation was not actually resolved to a satisfactory conclusion. The participants would often comment they were going to go back and have that conversation again, so make it a true learning conversation. Consequently, the researcher learnt to emphasise this at the beginning of every workshop, so that the participants could also use a previous example to work through. Again, this was a further example of learning through experience.

Similarly, during the workshop, often different conversation examples came to mind and the participants would change their original example as the session went on. This often occurred when the participants were being reflective about their involvement in the process. An example was when one participant commented that looking at both sides of the story, they realised they had not been clear about their expectations from the start, resulting in them criticising the individual unfairly. Again, as the workshops progressed, the researcher learnt to mention this aspect

at the beginning and how it was common to change examples, encouraging them to develop the one they felt the most comfortable with.

5.15 Personal and work examples

The Harvard technique identified examples from both a personal and work perspective, and it was during the first workshop when some participants were struggling to think of a work example, the researcher suggested they may find a personal example easier. This worked unexpectantly well and some participants commented they felt more confident practicing a personal conversation before a work one, so they could gain some experience. Again, this idea was suggested in all further workshops. It was interesting that in every workshop, there was at least one participant who would choose a personal, outside of work example, such as about their neighbours. One example was a participant's neighbour who always parked their trailer outside their window. Working through the five-stage technique gave the participant the confidence to have the conversation that evening, realising she had never honestly expressed her side of the story, so there were many assumptions involved. At the start of the workshops, the researcher would have been concerned about such non work examples, yet as the workshops progressed, these were welcomed as learning opportunities to help increase confidence, knowledge and learning autonomy (James & McCormick, 2009).

5.16 Confidence in delivery

The researcher also gained confidence in all the workshops, through all the positive verbal feedback that was provided by participants; such feedback has a powerful effect on increased confidence and wellbeing (Adams, 2005; Kamali & Illing, 2018). This positive feedback further developed as some participants walked into

sessions commenting how they had heard from their colleagues how good the workshops were. Another boost in confidence (and also highlighted the success of the workshop) were the comments at the end of every session, when many participants said they were going to have the difficult conversations that day or the next morning. Some participants even arranged challenging meetings during the break of the workshop. It was significant that some had booked a meeting immediately after the workshop, even before they had attended, so suggesting that perhaps even the thought of attending the workshop gave them confidence (Tabassi, Ramli & Baker, 2012). Within training, such motivation can influence how willing an individual is to attend the session (Maurer & Tarulli, 1994; Noe & Wilk, 1993) and how likely they are to then transfer this back to the workplace. Motivation is a more determinant role than any other individual factors when examining training performance (Wei-Tao, 2006). It became noticeable that often participants working in the same teams would book on the same workshop, commenting that they wanted to use a consistent approach for a difficult member of the team.

5.17 The timing of the workshop

The practicalities and timing of the workshop also made a difference to the perceived success of the sessions; this relates back to the importance of context in designing interventions (Nielson, 2017). The afternoon sessions did not seem to go quite as well as the morning ones, although the participants gave equally positive feedback. With reflection, this may have been due to researcher fatigue, although the sessions were also in different locations, with different room layouts so making it difficult to compare. Significantly, the afternoon sessions were also at the end of the shift, which had involved an early start for many of the participants. An example of an afternoon session that did not seem to go as well, occurred when the room was previously booked by a group of consultants who were running late.

They refused to leave the room until their meeting had finished and consequently the workshop started 20 minutes late.

The layout of the room was also significant, and the researcher found that sitting in rows was easier for group work, than sitting round a big table. Also, in one workshop one participant sat on her own on one side, whilst all the others were on the other side and the researcher had to request everyone change positions. This individual was also negative about the organisation and although took part in the workshop, was somewhat reluctant. However, in that workshop the projector repeatedly failed occurring 15 times in a two-hour session, that was really disrupting. This individual however was good at mending the projector, so gave her a role she relished and helped to get her more involved into the group.

Other issues in the afternoon occurred within one session, the group were not as engaged with the facilitated discussion. With reflection, the dynamics were different as a deputy manager of the department was a participant and another had unresolved issues with her line manager, so felt she could not participate in the group discussion. This individual stayed behind and discussed the situation at the end for 30 minutes; the opportunity to discuss confidential issues was something I then offered to other groups, as it worked so well on this particular occasion.

Often participants had examples that could not be discussed openly in a group, as either involved people in the room or maybe individuals that others knew. However, this situation interestingly worked well in other sessions, as sometimes people would discuss the same individual to see how they could help and support each other. When the teams knew each other, they generally provided more help and support, although the researcher was always aware that an anonymous situation may be recognisable to others within the workshop.

5.18 Chapter summary and links to the next chapter

This section outlined the design and delivery of an organisational intervention, specifically taking into account the unique context of an NHS trust and hospital setting. The intervention was piloted and adapted to incorporate the findings and key themes from the qualitative interviews in study one. The workshops were successfully evaluated by the participants with key reflections made by the researcher. A quantitative evaluation with focus on the impact of the intervention will be presented and discussed in the next chapter.

Chapter 6 – Intervention delivery and evaluation

6.1 Chapter overview

The previous chapter outlined the process in designing an intervention to give AHPs increased confidence and self-belief in managing situations with uncivil people, which was developed from the themes that emerged in study one. It was apparent how the designed intervention needed to examine different strategies from directly challenging the uncivil individual, to learning to live with the behaviour through various coping techniques. Building on these findings, this chapter will examine the effect of the resulting intervention, which was developed to address these needs.

6.2 Study research questions

In study 1, the following research questions were examined,

- Does uncivil leadership exist and to what extent is it part of the workplace culture?
- What effects does uncivil leadership have on the individual?
- What strategies do individuals utilise when experiencing such uncivil behaviour in the workplace?
- Do individuals challenge uncivil behaviour and to what results?

Answers to these questions were identified throughout the qualitative results of the interviews and led to the development of the intervention. Within this second study, the research aim is to develop and design an intervention on how to challenge and develop coping strategies towards uncivil individuals, resulting in positive outcomes for the target individual. This study builds on the results of study one, examining the final research question as below, which will be examined in this chapter,

- How can individuals be more effective at challenging incivility?

6.3 Intervention - to build confidence

This intervention focused on building confidence, which was measured through self-efficacy expectations, so the belief that an individual can successfully execute the behaviour that is required for a particular outcome (Bandura, 1977). When individuals are fearful of situations they see as threatening and beyond their coping skills, they will avoid them, whereas they will get involved with activities they believe they are capable of handling. This indicates how self-efficacy has a direct influence on the choice of activities, as well as expectations of success (Chen, 2017). In this study it was expected the intervention will increase individuals' levels of self-efficacy, and ultimately the beliefs they hold about their abilities to exercise control over uncivil events (Bandura, 1977).

There are various strategies to enhance self-efficacy, and this intervention focused on personal mastery experiences, which examines breaking down large tasks into smaller achievable ones and encouraging the individual to set specific and realistic goals. This increases self-efficacy in enhancing motivation and increased performance attainment (Bandura & Locke, 2003). In this study, this was achieved through a step by step learning process, as well as developing a personal challenging conversation goal for each individual after the workshop. Another strategy to enhance self-efficacy is the individual wanting to undertake the action (Bandura, 1977), which in this study is their challenging conversation. This was apparent throughout study one, as in the interviews many individuals commented they would like to have the skills and confidence to challenge the uncivil behaviour. Expectations of personal mastery within self-efficacy are important, as not only affect the initiation of the behaviour, but the ongoing persistence. Such efficacy

expectation will determine an individual's effort and how long they will persist in the face of obstacles. Strong perceived self-efficacy, then acts as a key determinant for the individual's efforts to succeed (Bandura & Locke, 2003). In line with above findings, it is expected that the intervention will lead to higher levels of self-efficacy, and therefore confidence, so hypothesising that:

Hypothesis 1: Individuals participating in the intervention will demonstrate higher levels of confidence after the intervention than individuals in the control group.

6.4 Intervention to build resilience

This intervention focused on increasing resilience, both when challenging conversations and also when developing coping strategies to deal with uncivil behaviour. The concept of resilience is fundamental to today's increasingly dynamic workplace, providing an understanding of how individuals cope with such adversity (Hartmann, Weiss, Newman & Hoegl, 2019), and seen as fundamental in contributing towards positive organisational behaviour (Luthans et al., 2007). Many definitions of resilience have been proposed (Robertson et al., 2015) and according to Fletcher and Sarkar (2012) resilience encapsulates both mental processes and behaviour in promoting personal qualities, as well as protecting an individual from stressors. Such a definition identifies both trait and process aspects of resilience, so something that is dynamic and can significantly change over time (Windle, 2011). Resilience is therefore seen as malleable (Robertson et al, 2015) so subsequently suitable for interventions. Workplace interventions in resilience are both feasible and effective in promoting positive strategies for coping and enhancing well-being, personally and organisationally (Pipe et al., 2012). Therefore, the second hypothesis is:

Hypothesis 2: Individuals participating in the intervention will demonstrate higher levels of resilience after the intervention than individuals in the control group.

6.5 Intervention to build confidence with different groups in the workplace

A theme that emerged through the interviews in study one, was regarding individuals being more inclined to challenge uncivil behaviour when it was directed at someone else, particularly their team, than when directed towards themselves.

As discussed throughout the interview in study one, prosocial behaviour and professional moral courage (Pouwels et al., 2019; Sekerka et al., 2009) may explain why individuals challenge uncivil behaviour more when directed towards one of their team, or this response could also be part of their leadership behaviour (Antonakis and House, 2014; Fleishman et al., 1991; Jeanes, 2019).

To the best of the researcher's knowledge, and as discussed in chapter 4 there is no research on defending or protecting your team against incivility in the workplace. Furthermore, the majority of incivility research has focused on the individual, rather than look at incivility within a team level (Yang, 2016).

As well as measuring individual's levels of self-efficacy and resilience, the study aimed to examine how the intervention would increase confidence in challenging uncivil behaviour across different groups and levels within the workplace. This was to be examined in two different situations, so when the uncivil behaviour was directed at themselves, or their team. The different groups are as below,

- a patient
- someone who is a lower grade than yourself
- a peer
- someone from another profession

- a consultant
- someone who is a higher grade than yourself

The study would examine if these behaviours had changed after the intervention, for all or some of the groups. Therefore, the final hypothesis is:

Hypothesis 3: Individuals participating in the intervention will demonstrate higher levels of confidence in challenging conversations when unreasonable behaviour is directed at themselves or their teams, for all of the six groups, compared to individuals in the control group.

6.6 Method

6.6.1 Participants and procedure:

The quasi-experimental design of this study consisted of pre and post measurements among 80 Allied Health Professionals (AHPs), mainly Physiotherapists in an NHS Acute Hospital Trust. Volunteer participants were recruited via an email from the Clinical Lead and asked if they would be willing to attend the workshop. These participants were recruited from the original group of 20 Physiotherapists who had taken part in the interviews in study one, as well as additional Physiotherapists and AHPs in the department. Participants completed a survey prior to the intervention (T1, pre-measure) which was completed via an email link sent out 2 months before the intervention workshop, and then (T2, post-measure) was completed immediately after the intervention workshop. The participant information sheet (Appendix L) and consent forms were completed (Appendix M) and collated at T1 and T2, with participants also receiving debrief information (Appendix N) following the workshops.

In between these pre and post measures, the participants carried on with their normal clinical role. Of the 80 people who participated in the intervention at T1, 80

continued and participated at T2, although this was split into an experimental group (n=50) and a control group (n=23). Due to operational constraints, such as leaving the workshop because of urgent clinical demands, as well as unmatched questionnaires, 7 people who participated in the intervention have not been included in the analysis.

The control group was created by requesting participants to complete the survey at T1, which was sent via an email link, and then also at T2, but before the intervention workshop. The time difference of 2 months in between T1 and T2, was the same in both the experimental group and the control group.

6.6.2 Intervention design

The participation in the intervention was voluntary. Prior to the intervention, a number of scoping meetings were held with the Clinical Lead, both face to face and also on the phone to design the intervention (section 5.5). It needed to meet the unique, dynamic, and fluctuating organisational demands of a clinical setting, yet also the individual needs of the AHPs.

The intervention was conducted in groups ranging from 4 to 20 people to reach as many people as possible, within the context of this clinical hospital setting. The intervention consisted of a 3-hour workshop and was delivered 7 times, to maximise numbers, whilst also accounting for shifts and fluctuating operational demands.

The follow up workshop was intended to be delivered 2 months after the initial intervention workshop, however, due to exceptionally high operational pressures and a department restructure at the hospital, the number of these workshops had to be restricted. Subsequently, only 2 follow up workshops were delivered, with 36 participants in attendance, so the collection of survey data was not undertaken.

Qualitative comments were obtained from the participants at the 2 follow up workshops, which are outlined in Appendix O.

6.7 Measures

Confidence was measured by assessing *Self-efficacy*, with self-efficacy scales (Bandura, 1977, 2006), examining the degree of confidence in conducting a challenging communication. Individuals were asked to rate their degree of confidence on a scale of 0 to 10, with 0 being no confidence, to a score of 10 being of high confidence. This scale of 1 to 10 is more sensitive and more reliable, and a stronger predictor of performance than a 5-interval scale (Usher & Pajares, 2008). In designing these efficacy items, it was essential the items reflect the construct and also the individual's perceived capability, as well as providing graduations of challenge (Bandura, 2006).

Resilience was measured using the Connor-Davidson Resilience Scale (CD-RISC). This scale was developed as a well validated measure to provide a self-rated assessment and quantifiable clinical measure of resilience, to assess the appropriate treatment response (Connor & Davidson, 2003). The CD-RISC has good internal consistency (Cronbach's α for the full scale was 0.89) and test-retest reliability (correlation coefficient of 0.87) and been tested both within clinical samples, as well as the general populations demonstrating sound psychometric properties (Burnes & Anstey, 2010; Connor & Davidson, 2003). The scale comprises of 25 items that measure resilience, the capacity to change and to cope with adversity. Example items include "able to adapt to change," and "have a strong sense of purpose". These 25 individual items are outlined in the survey (Appendix P). Individuals were asked to rate each item using a 5-point Likert scale (0 = not true at all, 5 = true all the time). The total score ranges from 0 to 100, with higher scores reflecting a higher level of resilience.

Confidence in having challenging conversations with different groups. The individuals were asked to rate their degree of confidence again from 0 to 10, but instead by focusing on the six groups, as listed above in 6.5. The participants were asked to rate their confidence in having challenging conversations with all these six groups, but across two different situations. First, when the unreasonable behaviour was directed at them and secondly, when the unreasonable behaviour was directed at one of their team. In this question the word "unreasonable" behaviour was used rather than uncivil, as the researcher felt this would be easier to recognise as a standard definition.

Assessing skills and learning - the last question examined the individual's confidence of their current level of skills and knowledge, when conducting a challenging conversation around inappropriate behaviour. This question intended to assess the level of knowledge and skills transferred from the intervention, back to the workplace. As regarding transference, the question was to be particularly relevant following the post workshops, but as these were not part of the data collection because of operational pressures, then this question was not included in the analysis.

6.8 Strategy of analysis

Self-Efficacy and Resilience – The data was analysed with IBM SPSS Statistics (Version 25) to test the intervention effects. Two-way mixed ANOVAs were calculated to test the difference in resilience and confidence scores over time (T1 and T2) and group (experimental and control).

Confidence in having challenging conversations with different groups - separate groups of paired t-tests were used to test for changes in confidence over time (T1 and T2) with Bonferroni correction applied, as multiple tests were being used.

6.9 Results

6.9.1 Changes in confidence scores over time

The descriptive statistics for confidence scores, are displayed in table one below, with data split into the experimental and control group. The total score is the scores over the change in time, irrespective of group. A two-way mixed ANOVA was calculated to test the difference in confidence scores over time and group. There was a significant difference and large effect in confidence scores over time, $F(1,71)=44.28, p<.001, \eta^2=0.38$, where confidence scores increased from time 1 to time 2. The main effect for group was non-significant, $F(1,71)=0.66, p=0.42$. Finally, there was a significant interaction, and large effect for the interaction between time and group, $F(1,71)=33.09, p=0.01, \eta^2=0.32$. As Table 1, and Figure 1 show, there was little change in confidence scores over time in the control group, however in the experimental group confidence scores increased from time 1 to time 2.

Table 6. 1 Descriptive statistics for confidence (self-efficacy) scores across group and time

		Time Point		
		Time 1	Time 2	Total
Group	Experimental (N=50)	5.95 (1.39)	7.58 (1.07)	6.77 (0.16)
	Control (N=23)	6.47 (1.42)	6.59 (1.19)	6.53 (0.24)
	Total	6.11 (1.41)	7.27 (1.20)	

Figure 6. 1 Two-way interaction between time and group for confidence scores

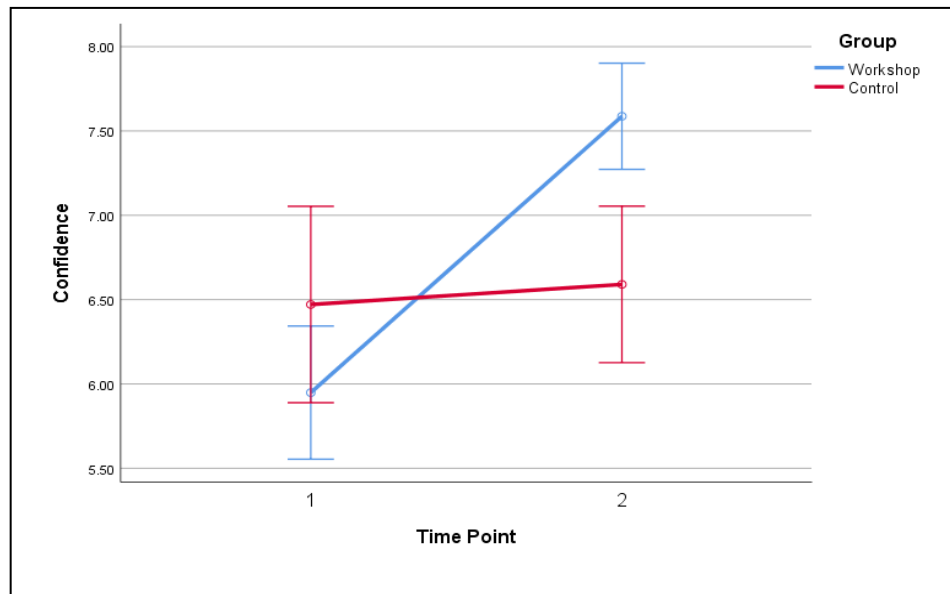


Figure 1 identifies that at time 1, as the error bars overlap, there is no difference in confidence scores between the two groups, but at time 2 there is a difference.

6.9.2 Changes in resilience scores over time

The descriptive statistics for resilience scores, are displayed in table two below, with data split into the experimental and control group. The total score is the scores at each time point, irrespective of group. A two-way mixed ANOVA was calculated to test the difference in resilience scores over time and group. There was a significant difference and large effect in changes in resilience scores over time $F(1,71)=14.17, p<.001, \eta^2=0.17$, where confidence scores significantly increased from time 1 to time 2, see Table 2. The main effect for group was non-significant: $F(1,71)=1.10, p<0.30$. Finally, the two way interaction between time and group was significant, and a medium effect size was found: $F(1,71)=4.8, p=0.03, \eta^2=0.06$, see figure 2. As Table 2, and Figure 2 show, there was little change in resilience scores

over time in the control group, however in the experimental group resilience scores increased from time 1 to time 2.

Table 6. 2 Descriptive statistics for resilience scores across group and time

Group		Time Point		Total
		Time 1	Time 2	
Group	Workshop (N=50)	131.48 (12.72)	138.22 (12.76)	134.85 (1.65)
	Control (N= 23)	130.86 (12.50)	132.65 (11.49)	131.76 (2.4)
	Total	131.29 (12.57)	136.47 (12.57)	

Figure 6. 2 Two-way interaction between time and group for resilience scores

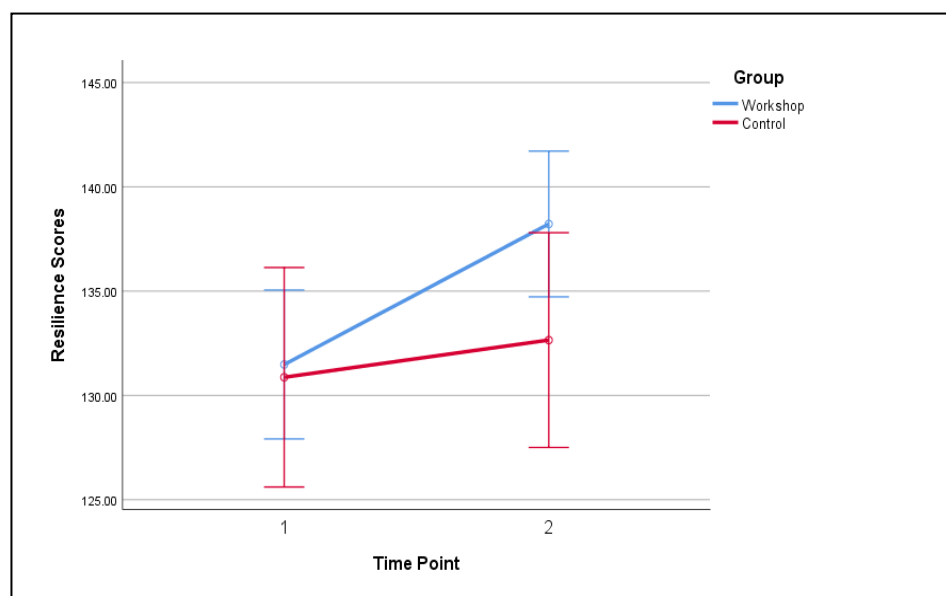


Figure 2 identifies that at time 1 and time 2, as the error bars overlap, there is no difference in resilience scores between the two groups.

6.9.3 Changes in self-reported confidence in managing challenging conversations with different groups

Participants were asked how confident they were in having a challenging conversation with six different groups in the workplace, and across two different situations. First, when the unreasonable behaviour was directed at them and secondly, when the unreasonable behaviour was directed at one of their team.

As identified in table 5, for both the experimental and control group at time 1, participants were more confident in challenging unreasonable behaviour when the uncivil behaviour was directed towards their teams, rather than towards themselves. Both groups were less confident about challenging the uncivil behaviour of senior colleagues or consultants. Separate groups of paired t-tests were used to test for changes in confidence from time 1 to time 2, with Bonferroni correction applied to account for the fact that multiple tests were being used, and the corrected alpha level was 0.004. There were no significant changes in confidence from time 1 to time 2 for the control group.

In the experimental group significant increases in confidence with medium to large effects were found from time 1 to time 2, and for having challenging conversations with all groups, whether the incivility had been directed toward others or themselves. Of particular note is the significant increase in confidence in having challenging conversations when the behaviour is directed at yourself, and this was apparent across all the six groups.

Table 6. 3 Difference in confidence in having challenging conversations at time 1 and time 2.

		Workshop Group (N=50)			Control Group (N= 23)		
		Time 1	Time 2	Difference between Time 1 and Time 2	Time 1	Time 2	Difference between Time 1 and Time 2
Directed at you	Patient	6.60 (1.82)	7.98 (1.42)	t(49)=6.46, p<.001, d=0.91	7.52 (1.08)	7.43 (1.34)	t(22)=.32,p=.75
	Lower grade	6.32 (1.70)	7.86 (1.29)	t(49)=8.50, p<.001, d=1.20	7.00 (1.51)	7.04 (1.49)	t(22)=.13,p=.89
	Peer	5.94 (1.52)	7.54 (1.42)	t(49)=8.97, p<.001, d=1.27	6.52 (1.44)	6.65 (1.40)	t(22)=.44,p=.67
	Other profession	5.88 (1.84)	7.54 (1.34)	t(49)=7.53, p<.001, d=1.06	6.70 (1.40)	6.52 (1.41)	t(22)=.64,p=.53
	Consultant	5.38 (2.01)	7.14 (1.58)	t(49)=7.48, p<.001, d=1.06	6.17 (1.85)	5.96 (1.66)	t(22)=.69,p=.50
	More senior	5.20 (1.83)	7.08 (1.54)	t(49)=9.34, p<.001, d=1.32	6.09 (1.62)	6.04 (1.74)	t(22)=.14,p=.89
Directed at your team	Patient	7.38 (1.72)	7.43 (1.34)	t(49)=5.38, p<.001, d=0.76	7.96 (1.02)	7.96 (1.26)	t(22)=.00,p=1.00
	Lower grade	6.92 (1.54)	7.04 (1.49)	t(49)=8.52, p<.001, d=1.20	7.70 (1.26)	7.65 (1.37)	t(22)=.17,p=.87
	Peer	6.44 (1.54)	6.65 (1.40)	t(49)=7.42, p<.001, d=1.06	6.91 (1.24)	7.35 (1.19)	t(22)=1.86,p=.08
	Other profession	6.44 (1.74)	6.52 (1.41)	t(49)=7.79, p<.001, d=1.10	7.17 (1.27)	7.09 (1.41)	t(22)=.46,p=.65
	Consultant	5.68 (1.94)	5.96 (1.66)	t(47)=8.53, p<.001, d=1.21	6.65 (1.72)	6.48 (1.70)	t(22)=.70,p=.49
	More senior	5.76 (1.65)	6.04 (1.74)	t(49)=9.74, p<.001, d=1.38	6.61 (1.50)	6.61 (1.85)	t(22)=.00,p=1.00

6.10 Discussion

The purpose of this study was to test the effectiveness of an intervention, that was to give AHPs increased confidence and resilience in managing situations with uncivil people. This was building from the themes in study one. The intervention aimed to provide the participants with different strategies from directly challenging the uncivil individual, to learning to live with the behaviour through various coping techniques. The intervention consisted of a 3 hour workshop on applying these strategies, by focusing on the participant's specific example, with the goal to initiate this challenging conversation after the workshop. A further follow on workshop was available 2 months after the first session.

As indicated in this section, the intervention was successful and levels of confidence and resilience in having a challenging conversation significantly increased after the intervention. The results also demonstrated a significant increase in the confidence of the participants in having challenging conversations across the six groups (see section 6.9.3) as well as within the different situations, so when the inappropriate behaviour was directed at themselves or their team.

As discussed above, the post workshop was limited, and within these workshops only written feedback and details of the facilitated discussions were recorded. Although the feedback was not analysed, it does indicate some interesting areas for further study. The details of this feedback highlighted that of the 33 individuals who attended the post intervention workshop, 85% of them had initiated a challenging conversation. The circumstances of these conversations ranged from being with members of their team, to patients and students on clinical placements. In relation to any incivility behaviours, one participant commented how they had responded to negative feedback directed at them, and another

discussed challenging a staff nurse, so cited a more senior member of staff. A full summary of the feedback and the discussions in the workshop, as well as further examples are provided in Appendix O.

6.11 Chapter summary and links to the next chapter

This chapter provided a summary of the intervention in study two. The intervention was successful, as levels of confidence and resilience in having a challenging conversation significantly increased after the intervention when compared to the control group. The results also demonstrated a significant increase in the confidence of the participants in having challenging conversations across the six groups (see section 6.9.3) as well as within the different situations, so when the inappropriate behaviour was directed at themselves or their team. A discussion of these results, as well limitations of the study and areas for future research will be in Chapter 8.

Chapter 7 Reflectivity – development and journey

7.1 Chapter overview

This chapter is a reflective professional evaluation of my personal development whilst studying for the professional doctorate. It will be organised into four sections, a discussion on reflexivity, my development prior to studying this doctorate, during the doctorate and afterwards as a consequence of the research.

The use of reflexivity needs to be considered alongside the three objectives of the professional doctorate, and these were to:

- Develop a range of advanced research skills and techniques which can be applied to their own area of practice;
- Make an original contribution to their field through developing skills to critically evaluate and translate research into practice; and
- Conduct applied research to produce a thesis which demonstrates contemporary thinking in occupational psychology. This thesis will be of a standard which can be disseminated /published in their own professional area.

7.2 Professional Doctorate Aims

In addition, the professional doctorate aims to develop occupational psychologists' ability to apply psychological theory to the real world, and to provide an evidence base for their practice. This is whilst also reflecting critically upon their own practice and to develop innovative solutions to real world problems. These aims and objectives are considered further in relation to my own development, both throughout and then as a summary at the end of the chapter.

Ensuring evidence was applied to the development of my practice was an important consideration (Briner, 2019) and one that I applied throughout the

doctorate. An evidence-based practice approach to any intervention involves using evidence from research, but also highlights the importance of using the local organisational evidence as well (Briner & Walshe, 2015). This thesis utilised the four elements model (Briner, Denyer & Rousseau, 2009) examining evaluated external evidence, the stakeholders' preferences and values, the context and lastly, the practitioner's experiences and judgements.

Within this doctorate, these four elements were firstly achieved by utilising information gathered from previous empirical studies (as within chapter 2 the literature review), secondly, to understand the stakeholder's perspective (the interviews with the AHPs within the NHS Trust), thirdly, the organisational context (operational demands and pressures for the NHS, in the literature review and in the interviews) and then finally, utilising the judgements and experiences of the practitioner as discussed in this chapter. Other experienced practitioners, both within occupational psychology as well as the clinical field, such as the Clinical Lead of the AHPs also helped to shape this doctorate. With the alignment of these four components then "evidence-based" decisions can be made (Briner & Rousseau, 2011).

7.3 Reflexivity

To reflect critically on the application of psychology within practice, it is essential to have an awareness of my role within the research study, and how I, as the researcher have affected both the process and the outcomes (Haynes, 2012). Reflexivity is the process of turning back and taking account of yourself (Alvesson, Hardy & Harley, 2008), and identifies a mutual affect, with an awareness of how both the object of the study and the researcher can affect one another (Alvesson & Skoldberg, 2000). Reflective practice is used within the Health sector (Timmins, 2006) and relevant to the area of this thesis, with many health professionals

referring to themselves as reflective practitioners (Rolfe, 2016), and this is the approach I have taken throughout the professional doctorate. As stated in the BPS Code of Ethics and Conduct 2018, psychologists are encouraged to reflect on their decision making to ensure they are acting ethically. Conducting such reflective research was a continual process, incorporating multiple layers and levels of reflection, through adopting various strategies into the reflexivity process, as recommended by Haynes (2012) and outlined below.

The strategies used enabled an ongoing process of reflexivity, throughout both my personal development and the development of the thesis, which enabled a reflexive knowledge production. A research diary was kept during the thesis process to write down feelings and thoughts, as increases ecological validity by recording what happened that day, rather than trying to record retrospectively (Reynolds, Robles & Repetti, 2016) and providing enough detail to give additional insights into complex phenomena (Popperton, Briner & Kiefer, 2008). This was particularly useful after the interviews and intervention study, as added personal depth to the fieldwork notes of observations and incidents. The use of written notes, as well as recordings on a mobile phone were utilised at various points, depending on the suitability of context, so for instance, reflective observations were recorded immediately after each intervention workshop, to ensure thoughts were not forgotten. The researcher also used the strategy of discussing the research subject and process with colleagues, to aid self-reflection (Braun and Clarke, 2016). These varied reflective processes are developed further in below (see section 7.5.8).

Within the context of Occupational Psychology as a profession, there is a need to understand the range of roles, levels and sectors that Occupational Psychologists work in and the importance of professional identity (Else, 2016). This identity of employment is complex and multifaceted (Nazar & Van der Heijden, 2012) and has

been important to me within the development of both my career and this thesis, as considered within the reflective process.

7.4 Prior to the Professional Doctorate

7.4.1 Business background

My background is in Airport Management, and whilst working at Heathrow and Gatwick, I was particularly interested in the areas of leadership, teams, learning and development. This experience of working in the business world has been fundamental to my interest in the applied areas of Occupational Psychology. After 9 years, I took a career break to study for a Masters at Sheffield University in Occupational Psychology. I was asked to undertake my thesis research back in the workplace at Heathrow, where I examined the effectiveness of their senior leadership development training programme. It is interesting how my choice of thesis then, is similar to this current study, identifying my long-standing interest within this field. My approach however has changed significantly, as I have a much deeper appreciation of the context and pressures of organisational life, as my experience, knowledge and identity as an occupational psychologist has increased.

7.4.2 Occupational Psychology

Following completion of the Masters, I gained chartered BPS status through various independent practitioner consultancy roles, as well as working for the Open University as an Associate lecturer in Psychology on their undergraduate, masters and prison programmes. I started work at York St John University in 2009, within the Psychology department and immediately refocused all my modules to include more applied aspects, such as current case studies and applying that week's news stories to Occupational Psychology. I also introduced a work placement with a

reflective diary assessment, so the students could relate their experience of the workplace to psychological theory. The student's evaluation of these modules considerably improved with these additions. I developed a third-year Occupational Psychology module, to enable students to experience this area of psychology as a future career option, which focused on organisational culture and organisational incidents studying human factors. Based on my previous business experience, this applied strand in my teaching was important for me, but on a personal development level, I felt my identity as an Occupational Psychologist needed to be also associated with the external business world. Consequently, I initiated and developed a University consultancy called "The Psychological Advantage". This offered a range of workshops, development programmes and study days to external businesses within the area.

7.4.3 University NHS health contract

As well as teaching undergraduate Psychology, I became involved with the University NHS Health contract and developed and delivered a range of external study days for NHS clinicians within the region. Following their success, it became apparent there was a gap in Allied Health Professional (AHP) leadership development, so in collaboration with a number of Clinical Leads in the region, I designed and taught a module on AHP Leadership. This was for clinical AHPs and formed part of a general Health and Social Care Master's degree. The module was different, as co taught with a range of leading NHS clinicians in the region. In 2014, this module was nominated and shortlisted for the National Times Higher Education external employment engagement awards, which on reflection felt like endorsement of this applied practice approach. In developing the module, I made numerous NHS contacts within the region, and as a result was asked to deliver

various study days, as well as longer bespoke programmes in the area of leadership, team building and stress.

7.4.4 Physiotherapy 360 leadership and development coaching programme

In one of the regional NHS trusts, the Clinical Lead for Physiotherapy asked me to help with her team of Band 7 Physiotherapists, as she wanted to focus on increasing their confidence and self-belief. Working collaboratively, we co-designed a 360 leadership development programme for the team of 40 senior physiotherapists, which consisted of a 360 questionnaire with individual feedback, followed by two further individual coaching sessions. The programme took 6 months and was delivered on site at the hospital.

The Physiotherapists' lack of self-belief and low confidence became a noticeable theme during these coaching sessions, yet interestingly, in some situations the Physiotherapists were incredibly confident and had extremely high levels of self-belief. The difference was fascinating and marked the start of my interest in this area, as well as the beginning of this thesis research. Until that point, in my academic career I had felt the pressure to undertake research, but not found an area I wanted to study. This area of research occurred naturally within my day to day role and was a tangible issue I wanted to explore further. It represented a real-world problem where I hoped I could make a difference. The themes that developed within these 360 leadership development programmes provided the initial questions for this research, as well as the ambition and motivation to study for a professional doctorate.

The value of this bespoke 360 leadership development programme was strengthened when it was nominated and won a regional NHS trust annual award for "transformation of a team culture". It was particularly encouraging that the

nomination for the award had been written by one of the participant Physiotherapists on the programme, as she felt the Physiotherapy team had indeed transformed. Attending the award ceremony and collecting the trophy with the Clinical Lead, reinforced my motivation and interest in undertaking research within this area, as I see how it had affected and improved individuals and team's working lives. With reflection, winning this award also helped my credibility for conducting future research within the team, as I gained their trust. I was also personally named on the trophy and my photo was on display with the Physiotherapy team in the main hospital reception, so reinforcing the benefits of this programme for a long period of time.

7.5 During the professional doctorate

At the same time as starting this doctorate, my role changed within the University and I became Head of Department and Acting Associate Dean. This brought the responsibility of the University's £1 Million NHS Health contract, as well as managing the Counselling, Occupational Therapy degree programmes and all student health placements. My contact within the NHS was now on a frequent and often daily basis. This was fundamental in increasing my understanding and knowledge of the health sector and the NHS, whilst also improving my confidence in this applied setting.

7.5.1 Resilience training and workshops

At a regular regional NHS meeting, I was asked by various Clinical Leads and the commissioner of healthcare programmes to develop a Resilience training workshop. They were aware of the success of the 360 leadership development programme and wanted a similar resilience workshop, which they hoped would address the problem of recruitment and retention within some areas of the Trust.

To meet this need, I undertook some resilience training called “Managing Personal Resilience” with Dr Mowbray and became a practitioner of the “strengthening personal resilience” programme. I started the delivery of this resilience training workshop to groups of clinical staff within NHS departments. It quickly became successful and as I could not meet the demand myself, I recruited two other members of staff within the university to assist in the delivery of this workshop. To date, the resilience workshop has been delivered to over 600 clinical staff within the region. The workshop groups have included a range of professions and levels, such as health care assistants, AHPs, nurses and consultants, who worked in various hospital areas, such as being ward based, the emergency department and end of life care. The changes and positive feedback after these sessions, again strengthened my interest in this area, as well as reinforcing the belief that I could personally make a difference through applied research.

7.5.2 AHP leadership Masters degree

Based on the previous success of the AHPs Leadership module, as well as the above resilience training, there became a growing realisation of the lack of specific AHP training and development within the region. Consequently, I designed a module on AHP stress and resilience to form part of a new Master’s degree focusing solely on AHP leadership. This was for all post registered clinical staff and within the first year became the most successful Masters within the University. It was fully funded by the regional NHS commissioners, as they stated such learning was fundamental to the current challenges within the NHS.

All of these previous developments were significant in my background knowledge of the NHS, and in particular, AHPs. With reflection, this provided the confidence to start this research. The interviews in this thesis were all within the Physiotherapy

department where the 360 leadership development programme had originally taken place. The participants had been part of this programme, as well as attending some of the other workshops I delivered. A few individuals had also been students on the AHP Masters module at my University. This gave me credibility as well as empathy, as the participants knew I had an appreciation of their roles and the pressures involved. I believe this provided richer conversations in the interviews, as many individuals did comment, either before or after the voice recorder was switched off, that as they knew me and trusted me, they could be truthful in their conversations.

7.5.3 University lead on health

Within my professional life, my role changed again, as the University underwent a restructure and I became Head of School for Health. I continued to manage all the areas of the NHS Health contract, worth £1 Million, as well as the Occupational Therapy degree programme, but in addition managed the Physiotherapy and the Biomedical Sciences degrees. I became the University lead on Health and as such, the University representative to attend the National Council of Deans of Health meetings. All these changes continued to develop my confidence within the field of Health and provided greater knowledge and context for this thesis. In managing the Physiotherapy programme in particular, I developed not only an understanding, but a respect and admiration for the profession. This was important to the research, as gave me increased motivation to achieve the best outcomes for the physiotherapy teams I was working with.

7.5.4 Value of research led teaching

As part of my doctoral thesis, the first data collection was conducting the interviews and these findings also started to inform my teaching. With this increased

knowledge, I developed some bespoke leadership programmes with other NHS trusts in the region. It was noticeable how within this time period, my professional and research skills grew. There was a circular exchange of knowledge and personal growth, as both my teaching and research reinforced and strengthened each other. With reflection, my knowledge, confidence and credibility all developed and emphasised to me the value and importance of research led teaching. I began to use many applied clinical examples and case studies within my teaching at the University.

7.5.5 Progression as an Occupational Psychologist

Since completing my Masters at Sheffield University in Occupational Psychology, it was important for me to develop professionally within my career, and also as a psychologist. I became chartered in Occupational Psychology in 2010 following completion of a supervised portfolio. The applied approach of reflecting on my evidence-based practice was informative and rewarding, and so the next progression point to aim for was a professional doctorate, as would continue my development and applied knowledge within the field.

7.5.6 Reflection on own leadership style

During this time, when undertaking the research and also the teaching, it continually made me reflect on my own leadership style. When teaching leadership in the Masters module and listening to the student's case studies, it reinforced to me the impact and responsibility I have as a line manager on all my team, for instance appreciating how my attitude and behaviour could impact their wellbeing. Within the Stress and leadership modules, the research identified how the biggest influence on your stress is your line manager, and how good leadership can enhance mental health and wellbeing (Donaldson-Feilder & Lewis, 2016). Such

evidence made me reflective of my behaviour, for instance how I communicated in team meetings or how I reacted to stress, as well as the language and tone I used in all communication.

This self-reflection was also apparent with the resilience training, as delivering the workshops continually increased my own personal resilience and self-awareness (Robertson et al., 2015). Examples included being aware and respectful of work and home boundaries, so being reflective of when in the day I contacted my team, as well as being mindful of the need for recovery time, so deleting work emails from my personal mobile.

7.5.7 External training and development – University wide

My role changed again at the university, as after 18 months, I was asked to become the Director of The Advantage, which was a new team set up to lead on all professional training and development across the University. This role increased my professional customer skills as I was the external face of the University, often representing the organisation at different business events. I instigated my team achieving a “Customer first award” and was the only department in the University to have this customer service recognition. This knowledge then reapplied back to my research, as when developing the intervention, I was able to design this workshop with a more external customer focus.

7.5.8 Training and development and reflection on my own personal development

The above Director role made me reflective about training and development and the need of the University to remain competitive, whilst also having the stability of experience and credibility. This was a theme I also applied to my own personal development, as felt it was important to keep up to date and abreast of current

knowledge. Consequently, due to the popularity and demand of resilience training within the NHS, I wanted to expand my own knowledge, so trained with The Wellbeing Project and became a practitioner for the WRAW (workplace resilience and wellbeing) psychometric tool. Retraining and diversifying my knowledge, then enabled me to develop further resilience programmes and a range of resilience interventions.

My identity as an Occupational Psychologist was key throughout the development of this new role, as I ensured that all the training was evidence-based. The programme aims and objectives of this doctorate were also vitally important, as I wanted to ensure that all the training could be applied to the real world. Every delegate therefore left the training with tools and techniques that were evidence-based yet could be applied to their workplace, such as with thinking errors (Hollan & DeRubeis, 2009) within resilience workshops.

During this time, I started to deliver resilience within schools and also leadership teams within schools and universities. This expansion of training within resilience developed my personal knowledge, but also provided an interesting comparison of different professions, as well as emphasising the importance of being reflective in practice. An example that was particularly noteworthy, was in a school resilience workshop, where a sports teacher was complaining about staying late for after school clubs, and how stressful this was for him. In my mind, I kept comparing this example to a recent NHS workshop where a nurse was discussing the life and death pressures of working in the emergency department. I inwardly became increasingly irritated with the teacher, as felt his example seemed minor in comparison. My attitude was not professional, nor relevant, as interpersonal comparisons of stress are not beneficial, nor related to the evidence (Cartwright & Cooper, 2011).

This incident did highlight the importance of continually being self-reflective and how attitudes and experiences can impact both teaching and research. In addition, undertaking the majority of my work within the NHS and the area of stress and resilience could also have resulted in some compassion fatigue (Sinclair, Raffin-Bouchal, Venturato, Mijovic-Kondejewski & Smith-MacDonald, 2017), so a minimised ability to emphasise with participants in the workshop (Denne, Stevenson & Petty, 2019).

7.5.9 External influences and reflection on the Intervention design

Attending the training with “The Boss Whispering” (Crawshaw, 2007) company was an important reflective experience for me, with regards to my intervention design. As discussed in section 5.7, Crawshaw uses a coaching method that enables the managers to see the impact of their behaviour (Fazzi, 2008). However, when attending the training it seemed lacking in evidence, as well as completely dependent on the manager being referred by Human Resources, so implying they had little choice to attend the coaching. This made me reflect on my intervention design, and in particular, how I needed to ensure the intervention was not only evidence-based but that it focused on the issues identified in study one. Although getting uncivil managers to attend such a coaching session would be complex, significantly this was not the aim of the intervention. The aim was to increase the confidence and self-belief of the Physiotherapists, so this reinforced my intention of working with the individuals who have to cope with such incivility on a daily basis, rather than the leaders or consultants themselves.

Another noteworthy external experience within my doctorate programme was training with ACAS in internal workplace mediations skills. This was excellent in providing me with the knowledge and confidence to then develop my own

intervention workshop, as I could see the benefits of such applied and trusted techniques (Hughes, 2006; Urwin, Latreille & Karuk, 2012).

7.5.10 Reflection on the Professional Doctorate aims and objectives

As previously outlined, reflexivity is an awareness of how both the object of the study and the researcher can mutually affect one another (Alvesson & Skoldberg, 2000). When considering the objectives of this professional doctorate, as a practitioner, I have enhanced both my applied and theoretical understanding of Occupational Psychology. Relating back to Elsey (2016) my identity as an Occupational Psychologist has strengthened, evolved and been clarified, as discussed in the next section.

7.6 Post doctorate

This thesis has made a fundamental difference to my professional life, as has taught me the importance of researching real world issues and the value of research informed teaching. The doctorate has also boosted my confidence and knowledge as an Occupational Psychologist, as although I previously had experience in applied areas, there was a gap with regards to research. Developing skills to use new research tools, such as NVivo and learning the technique of template analysis has been incredibly rewarding. Having completed this thesis, I now understand the importance of both research and applied practice and their mutual dependency.

Throughout the professional doctorate, I have become more reflective as a leader and more confident about engaging in a challenging conversation, from my awareness of the many impacts of such behaviour. A number of people have recently commented how they notice how I am confident to initiate challenging conversations at work, and with self-reflection, I realise this is a result of the

professional doctorate studies. Having undertaken this research, it almost feels like I have a responsibility to challenge.

Reflecting whilst writing this chapter, I realised that my identity as an Occupational Psychologist has developed and strengthened through the stages of my career (Else, 2016). This identity has been varied, depending on the focus of my job, my experiences and life changes (Nazar & Van der Heijden, 2012). The gradual increase and change in my identity as an Occupational Psychologist provided the impetus to take the decision to leave academia and pursue a role back in the private sector. Importantly, I wanted to work in an area where I felt my increased knowledge, both in applied and theoretical aspects of Occupational Psychology would be relevant, so I have recently started a new role as Head of Client Delivery at The Wellbeing Project. The attraction to this organisation, is that they recognise wellbeing and resilience as key enablers of employee engagement, but also see it as essential for a high-performance workplace culture. As well as being responsible for all client delivery, part of my role is to manage a team of experienced Occupational Psychologists, which with reflection, prior to this thesis, I would have been apprehensive about. As my identity as an Occupational Psychologist has increased with this doctorate, so has my self-belief and confidence.

7.6.1 Career identity

Being reflective on my changing career and also my career identity has been enlightening. The many different roles throughout this doctorate period identify proactive and adaptive career development (Rudolph, Zacher & Hirschi, 2019) and self-managed work-related transitions (Savickas, 2011) which are significant to my identity as an Occupational Psychologist. Through seeking applied Occupational

Psychology opportunities within every new role, this has developed my career identity and given a structure of meaning, apparent in how my career path has always linked with my interest, motivation and competences (Meijers, 1998). This thesis has aligned my personal, role and organisational identity (Elsay, 2016) and I am confident will continue to do so, as career identity is longitudinal, so an appreciation of past, present and future (Fugate, Kinicki & Ashforth, 2004).

7.7 Chapter summary and links to the next chapter

This chapter has summarised my personal development and journey throughout this professional doctorate programme, focusing particularly on my increasing identity as an Occupational Psychologist. With regards to the aims and objectives of the doctorate, these were all met, and with reflection the importance and necessity of evidence-based practice in real world settings was particularly reinforced, as discussed further in Chapter 8.

Chapter 8 – Discussion and conclusion

8.1 Chapter overview

This concluding chapter of the professional doctorate examines the research questions, through a discussion of the two empirical studies; the 20 Physiotherapy interviews in study one (chapters 3 and 4) and the evaluation of the intervention workshop in study two (chapter 6). As the detail of each study was discussed in the respective chapters, the focus of this chapter is to combine and discuss all the findings, with reference to the research questions, as well as the professional doctorate research aims, as outlined in chapter 1.

An outline of the limitations will then be presented, with suggestions for future research. The chapter concludes with a summary.

8.2 Research questions

The professional doctorate focused on the following research questions, and these will be answered systematically in this chapter:

1. Does uncivil leadership exist and to what extent is it part of the workplace culture?
2. What effects does uncivil leadership have on the individual?
3. What strategies do individuals utilise when experiencing such uncivil behaviour in the workplace?
4. Do individuals challenge uncivil behaviour and to what results?
5. How can individuals be more effective at challenging incivility?

8.3 RQ1 Does uncivil leadership exist and to what extent is it part of the workplace culture?

This research question was examined during the first study, when 20 Physiotherapy professionals participated in semi-structured interviews with a focus on leadership and incivility within their workplace context. The template analysis findings illustrated examples of uncivil leadership, confirming that it did exist in the workplace, and was an everyday part of the organisational culture. This was to such an extent that participants (section 3.9.1) did not even question its existence (Leiter, 2013). Uncivil leadership within the culture was apparent through many of the words often used by the participants, so god-like, untouchable, old school, (see sections 3.9.2 & 3.9.3) and these described a certain type of consultant who displayed this uncivil behaviour. This identified a common cultural language (Schein, 1993) that was maintained through processes such as, socialisation (de Swardt et al., 2017). This research question will be explored further by examining how the participants would often justify the uncivil behaviour within the workplace; this is discussed in the section below.

8.3.1 Cultural justifications of uncivil behaviour

When uncivil behaviour was discussed in the interviews, it was always justified, and a rationale offered, further identifying it to be part of the workplace culture. The reasons for the incivility were explained as either internal, such as the consultant's personality or social skills (section 3.10.1), or external reasons, for instance the stressful nature of the role (3.10.5) or pressures of the NHS (Mosley & Lockwood, 2018). As these justifications of incivility were all relatively stable or long term, it would be interesting to explore whether they reinforce the stability of the prevailing workplace culture.

Such long-term justifications would often be the reason why the Physiotherapists said challenging the uncivil behaviour was difficult (section 4.2.3). In the interview findings, the reasons offered for not challenging the incivility focused on aspects of the culture, through both formal and also informal structures. The formal structures centred round seniority, medical hierarchy (McCloskey et al., 2019) and lack of management and governance (Thompson & Catley, 2018), resulting in the consultants being almost untouchable. Whereas informally, processes such as social identity theory (Burford, 2012; Tajfel & Turner, 2004) socialisation (de Swardt et al., 2017) and professional identity (Lempp & Seale, 2002; Weaver et al., 2011) reinforced the acceptance of uncivil behaviour, as engrained in the past and present culture.

Within study one, the participants consistently showed respect towards consultants with clinical specialism and experience; this was despite their behaviour. This clinical expertise was often discussed as acceptable rationale for not only the uncivil behaviour (section 3.10.2), but also as a further justification for not challenging it (section 4.2.4). This was an interesting aspect of workplace culture and as far as the author is aware, a gap in the literature, highlighting a novel area for future research.

8.3.2. Consultants clinical and social skills

In study one, consultants were discussed and rated by their expertise and clinical skills, with any social skills seen as a positive addition, rather than a required aspect of their role. Communication was therefore a desirable attribute, rather than an integral part of being clinically skilled, as supported in the literature (Riskin et al., 2015). Ultimately, consultants could be rated highly with specialist clinical skills, but still have poor social attributes (Youngson & Flin, 2010). This was noticeable when Physiotherapists described themselves as lucky to work with consultants

who had good social skills, so different from the norm. Significantly, the Physiotherapists never used the word unlucky when working with uncivil consultants, as this behaviour was seen as standard and accepted as part of the culture.

An Individual effect of the poor social skills of the consultants, was apparent in the additional role that the Physiotherapists would often have to fulfil, as a mediator in between the consultant and the patient. This was also apparent when the incivility was remote, so when the consultant was uncivil without the Physiotherapist being present, such as promising Physiotherapy treatments but not informing them. This additional role could be an area for future research, particularly in how the behaviour was justified and the subsequent coping techniques.

8.3.3 Changes in culture and incivility

The extent of uncivil leadership being part of the culture was evident in how the prevalence of uncivil consultants was often used as a gauge to describe changes in the workplace (section 3.9). For example, a recognition that fewer uncivil consultants than in previous years marked a positive change in the culture. Although this was seen as a welcome change, it was paradoxically used as a justification for not challenging current uncivil behaviour, as the Physiotherapists seemed almost grateful for the cultural shift and improvement. This attitude further identifies how incivility is accepted as part of the culture, rather than questioning its actual existence. The acceptance of incivility (Salin, 2003) as part of workplace culture, also suggests why many were reluctant to challenge (Carter et al., 2013) and supports why passive coping strategies were often adopted, as discussed in RQ3 (section 8.5) below.

8.4 RQ2 What effects does uncivil leadership have on the individual?

Throughout the interviews, the Physiotherapists discussed many effects from the uncivil leadership, and as examined in chapter 3, these ranged from being frustrated, unmotivated and even frightened in some examples. Participants felt stressed when working with certain uncivil consultants and rumination (Niven et al., 2013) was particularly noticeable in anticipating a discussion with these consultants (section 3.8.2). It was also apparent that the effects of incivility went beyond the individual and had further consequences, impacting both performance and ultimately patient care. A common example discussed in the interviews was needing to prepare more thoroughly for patient discussions with uncivil consultants, as the Physiotherapists were only given a short amount of time to speak, before being cut off. This lack of open and honest patient discussion was highlighted by many participants as not only stressful, but also having an impact on patient care.

8.4.1 The effect of incivility on communication, consistency of behaviour and patient care

When describing uncivil behaviour, participants reported a lack of consistent behaviour and moodiness of the consultant. The Physiotherapists described how they never knew what to expect when the consultants were on duty (section 3.8). This effected communication, as limited patient discussion and often resulted in conversations being brought to an abrupt close. This lack of communication was noticeable on how it impacted patient care. For example, rather than engaging in a discussion, the Physiotherapists would change their patient treatment to suit the consultant, reverting back to their preferred practice when the consultant was not on duty. This area was discussed in the interviews and resulted in a negative effect on the Physiotherapist's professional identity and pride (Lempp & Seale, 2002).

This was a significant finding of the study and a gap in the literature. It also highlights an area of research that is critically important as identifies how incivility within a ward setting can directly impact patient care.

8.4.2 The effect of incivility on being more reflective

Working with an uncivil consultant made the participants more reflective of their own behaviours, particularly their communication and leadership style, as they had personally experienced the effects of incivility (section 3.8.6). The Physiotherapists were also reflective about their own coping abilities and the necessity of resilience when working with uncivil consultants (section 3.8.4), although interestingly they never discussed how their resilience could be strengthened through other areas. As well as being reflective about the consultant's behaviour, they had all previously thought why the leaders behaved in an uncivil manner. This reflection and subsequent justification for the uncivil behaviour may then have had an impact on the Physiotherapists coping techniques, and how they reframed and rationalised the behaviour (Hershcovis et al., 2018; Lazarus & Folkman, 1984) which is an area for future research.

8.4.3 RQ1 and RQ2 summary

The research questions RQ1 and RQ2 have been answered in the above sections and clearly demonstrate that uncivil leadership does exist and is part of the everyday workplace culture. This was apparent through common language shared, as well as the similar justifications of the uncivil behaviour. Many of these reasons were also cultural, excusing the behaviour through the pressures of the role for instance. The effect of incivility on the individual were wide ranging, but then also affected performance, professional pride and ultimately patient care, such as changing clinical practice when the consultant was present. Of particular note was

the respect for the consultants' clinical specialism. This was a constant rationale for justifying the behaviour despite its individual effects, and as apparent in the next section, this was also significant in challenging the behaviours. This will be explored below.

8.5 RQ3 What strategies do individuals utilise when experiencing such uncivil behaviour in the workplace?

Many different strategies were used when individuals experienced uncivil behaviour, and consistent with the literature (Cortina & Magley, 2009), there were a range of coping techniques that were either problem solving, or emotion focused (Lazarus & Folkman, 1984). The problem-solving techniques, such as confrontation are discussed in research question 4, whereas the emotion focused techniques are examined below. Similar to the literature (Salin et al., 2014), the Physiotherapists used emotion-focused techniques such as ignoring the uncivil consultant, more often than utilising assertive strategies such as, confrontation (Cortina & Magley, 2009). As discussed in chapter 3 (section 3.9.3), the acceptance of incivility as part of workplace culture, also suggests why there was a reluctance to challenge, as many felt the behaviour was beyond challenging (section 4.2.3), hence why passive coping strategies were often adopted. The readiness to adopt such passive coping strategies may be shaped by the culture and environment, so an aspect worthy of future research.

8.5.1 Emotion focused coping strategies - justification and avoidance

Justification of the uncivil behaviour was a particularly noticeable coping strategy and one used by all the participants. As discussed above, the behaviour was normalised as an everyday occurrence, so explained as systematic of the prevailing workplace culture. The relationship between culture, incivility and

rationalising the behaviour would be an interesting area to examine, to see if there is a relationship between the effectiveness of this coping strategy and the type of justification used.

The coping strategy of avoidance was discussed in many examples in the interviews (section 3.8.4) although differed in the type of avoidance, as ranged from physically avoiding the consultant on the ward, to avoiding having a conversation with them. However, this also had another impact; when the Physiotherapists knew they had to engage in a discussion with the uncivil consultants, their coping strategy was extra preparation, knowing they only had a short time to discuss their questions before the consultant shut down further communication. As discussed in chapter 3 (section 3.8.2) the lack of open, honest and respectful conversation between the two professions was a noticeable consequence of the uncivil consultants. Avoidance, despite being a frequently used coping strategy, had detrimental effects and did not seem to remove the negative emotion associated with incivility, as associated with greater emotional exhaustion, enacted incivility and less forgiveness (Hershcovis et al., 2017). In taking into account the context of high pressured and emotional caring roles, where problems of compassion fatigue are already apparent (Sinclair et al., 2017), these findings confirm a need for further research in examining the longer-term consequence of using these approaches.

8.5.2 Humour and team bonding

The use of humour and team bonding was a coping strategy that was used when experiencing uncivil behaviour. The use of shared humour particularly at shift handover when certain consultants were on the ward, was a way of generating group cohesion (Romero & Pescosolido, 2008) and camaraderie (Romero & Cruthirds, 2006; Vaill, 1989). As the humour was directed towards the uncivil

consultant, some expressed guilt, yet simultaneously identified comfort as well. As humour can often be associated with incivility, this highlights an important area for future research. It is critical to understand the dynamics between humour and incivility further, particularly where humour might morph into incivility or where humour can be interjected to reduce conflict or where it might be viewed as inappropriate.

The importance of team bonding, strength of team identity and how that shapes actions, was particularly noticeable when the Physiotherapist protected their team from uncivil behaviour. This is in support of social identity theory (Burford, 2012; Tajfel & Turner, 2004;) socialisation (de Swardt et al., 2017) and professional identity (Lempp & Seale, 2002; Weaver et al., 2011). This was apparent in various ways, such as by initiating conversations with uncivil consultants on behalf of their team, warning the rotational band 5's about incivility or confronting a consultant when uncivil behaviour was directed at one of their team. The protection of the team was an important theme, relevant to both this research question and research question 4, as to whether individuals challenge uncivil behaviour and to what results? As discussed further in this chapter, it was often critical in determining whether Physiotherapists had the confidence to challenge and confront the uncivil individual.

8.5.3 Needs of the patient

Whatever coping strategies were adopted, the participants always described the needs of the patient; examples included ensuring greater preparation for patient conversations with the consultant, rather than avoiding them, or taking on the role of mediator between the consultant and the patient (section 3.11.2). Within the organisation, exploring how culture shapes coping strategies with the resulting individual effect and consequences for patient care, is a critical area for future

research. This also identifies how any incivility research in healthcare, that does not consider the context and patient aspects will be limited, as missing out on critical influential factors.

8.6. RQ4 Do individuals challenge uncivil behaviour and to what results?

Research question 4 focused on examining whether individuals challenge uncivil behaviour and what results were obtained. In chapter 4 participants described how uncivil behaviour was challenged, although as discussed later in this section there always seemed to be specific circumstances when this was done. Generally, a myriad of reasons was provided for not challenging. These ranged from the consultant's personality and social skills, (so not applicable or worth challenging), to not having the emotional energy or appropriate skills. An acceptance of the uncivil behaviour as part of the workplace culture was often mentioned as a rationale for not challenging, as well as comparing to the past, so being grateful that uncivil consultants were now in the minority.

8.6.1 Challenging seniority and when incivility directed to the individual or their team

Challenging uncivil behaviour was also often seen as inappropriate due to the seniority or clinical specialism of the uncivil consultant (Carter al., 2013). This respect for clinical expertise, was also mentioned in how the consultants would be difficult to be replaced, so almost beyond challenging. A situation where challenging always occurred, irrespective of seniority and clinical specialism, was when a consultant was uncivil to a member of the Physiotherapist's team. It was though a line had been crossed, and the participant would then always intervene and challenge. In these circumstances, it did not seem relevant how specialist the consultant was, as the strong team identity (Mitchell et al., 2011) prevailed. The

Physiotherapist would also often defend and challenge the uncivil behaviour if directed toward Physiotherapy as a profession, (Lempp & Seale, 2002; Weaver et al., 2011) although this seemed to occur more if involving a member of their team, rather than incivility towards them as an individual.

The motivation to challenge on behalf of their team seemed to overcome any confidence or lack of skills issues, as these were never discussed in such situations. This confidence was not so apparent when the uncivil behaviour was directed towards them as individuals; the contrast was stark. Instead of challenging on behalf of themselves, the participants would offer a justification for the behaviour, so often letting it go unchallenged.

This aspect of team identity was a critical finding in the research. It suggests there may be merit in developing interventions where different values in team identity could be encouraged, so that uncivil behaviour is not seen as appropriate, as well as different values surrounding challenging. Further research also needs to examine the relationship between team identity and incivility, particularly in relation to how it facilitates challenging uncivil behaviour.

8.6.2 Difference between confrontation and challenging and the impact of humour

An important distinction was apparent during the interviews that confrontation and challenging were discussed differently. Confrontation was described as more in the moment, so an instant reaction, whereas a challenge involved a planned conversation, so feeling more controlled. This would be an interesting aspect to explore further to see if the participants also felt this was a distinction, and how it then affected the success at challenging, as well as their resulting coping strategy. When participants did challenge or confront the uncivil behaviour, there were

mixed results. However, although this range of responses is consistent to earlier studies (Cortina & Magley, 2009), a notable gap in the research is a more comprehensive understanding of this actual challenging or confronting experience, and what factors influence its success and failure.

Within study one, the success of challenging was described in various ways, such as whether the incivility stopped or whether the consultant apologised. The use of humour was particularly noticeable in getting the consultants to understand the impact of their incivility, and an effective strategy in challenging the inappropriate behaviour by reducing conflict (Ponton et al., in press). The success of this technique may also be attributed to the fact that humour discussed in the study was a planned conversation, and therefore not an instant reaction, or in the moment confrontation. Alternatively, the success could be the use of the actual technique of humour, as not a direct challenge to the consultant's seniority (section 4.2.11). These reasons, or a combination of both, further emphasise the need to examine how humour can contribute to the successful challenging of incivility through future research.

8.6.3 Confronting and challenging the uncivil behaviour and subsequent results

Most confrontations to the uncivil behaviour resulted in the consultants saying they were too busy, not listening and walking away. When Physiotherapists did confront or challenge, but the consultant's uncivil behaviour stayed the same, it had a negative effect on their confidence (section 4.2.9). A consequence of this may be their confidence to challenge in the future, indicating the importance of self-efficacy, as measured in the intervention in study two. The critical part of any such intervention within incivility, needs to help increase participants self-confidence to challenge. Such challenging, although not preventing the recurrence of incivility,

may provide the opportunity for the individual to exert control and let go of the negative emotion of stress, resulting in a cathartic effect (Hershcovis et al., 2018). This identifies how any intervention needs to focus primarily on problem solving coping techniques, to ensure successful challenges, as well as improved benefits for the individual (Hershcovis et al., 2017).

8.6.4 The need for training and skills in challenging conversations

Participants described how they would like to challenge uncivil behaviour, based on mutual respect, with a direct and honest conversation. As discussed in chapter 3, such open conversations with the consultants were rare, and often a source of anxiety for the Physiotherapists. The experiences of participants when trying to challenge the uncivil behaviour, reinforces the need for training to support challenging conversations; many discussed how they would like to have the confidence and skills to be able to challenge. The need for training that focuses on open and honest communication, that increases self-confidence and is based on a planned challenging conversation, rather than a confrontation, resulted in the design and delivery of the intervention workshop in study two.

8.7 RQ5 How can individuals be more effective at challenging incivility?

Study one identified that uncivil leadership did exist in the workplace, that it had an effect on the individuals, as well as ultimately patient care. It also identified that Physiotherapists had a willingness to challenge incivility, but often a range of factors prevented it. These findings established a clear organisational need to develop an intervention to help facilitate the ease and effectiveness of challenging. Building on the findings of study one, the aim of the second study was to design an intervention on how to challenge incivility, as well as develop coping strategies resulting in positive outcomes for the individual.

8.7.1 Research questions and hypotheses

This second study examined the last research question, focusing on how individuals can be more effective at challenging incivility. It was answered through the development of the evidence-based intervention, by designing and delivering a workshop to increase confidence and resilience in challenging conversations.

The intervention study had the following hypotheses:

Hypothesis 1: Individuals participating in the intervention will demonstrate higher levels of confidence after the intervention than individuals in the control group.

Hypothesis 2: Individuals participating in the intervention will demonstrate higher levels of resilience after the intervention than individuals in the control group.

Hypothesis 3: Individuals participating in the intervention will demonstrate higher levels of confidence in challenging conversations, when unreasonable behaviour is directed at themselves or their teams, for all of the six groups, compared to individuals in the control group.

As discussed in chapter 6, the intervention was effective as levels of confidence and resilience significantly increased after the intervention workshop. The results also demonstrated a significant increase in the confidence of the participants in having challenging conversations after the intervention, when measured across the six groups. This increase in confidence was also significant across both situations, so whether the inappropriate behaviour was directed at themselves, or at their team (see section 6.9.3).

8.7.2 Confidence when challenging senior staff and consultants

The aim of the intervention by focusing on difficult conversations in general, rather than specifically uncivil leadership, was also effective. As identified in the results it increased the participants' confidence when engaging with senior staff and consultants, both when the behaviour was directed at their team or themselves. This was a critical outcome as participants had reported in study one, that while they were willing to challenge incivility on behalf of the team, they possessed low confidence when challenging uncivil behaviour directed at themselves. This is beneficial to the organisation and contributed to addressing this research question regarding effectiveness.

Examining the levels of confidence when challenging within the different groups, as well as when the behaviour is directed at themselves or their teams, would be an interesting area for future research. For instance, particularly looking at different variables, such as the hierarchical levels in more detail or the different clinical specialisms of the consultant. Areas for further research would be to examine if the resilience and confidence levels will continue over time, and to further scrutinise contextual factors of which individual, team and organisational aspects may influence and support this. In particular, longitudinally of interest would be how levels of resilience and confidence may be affected after unsuccessful conversations, as well as how they will impact future intentions to engage in challenging conversations.

Of particular importance, is understanding the healthcare context and culture within the design and planning of any healthcare intervention studies. These aspects were key in this evidence-based intervention (section 5.3), although as highlighted by Nielson & Randall (2013) there is an overall scarcity of interventions that consider such contextual aspects.

8.8 Limitations of the research

As far as the author is aware this is the first study to undertake research within a clinical Physiotherapy team that examines uncivil behaviour. It has consequently produced a number of new insights for further study. However, the lack of previous published intervention studies, also highlights the reasons why such research is scarce, as there are many difficulties and constraints within a clinical environment. Limitations within this study include the design; by only focusing on one NHS Trust, this limits the findings to other clinical settings. The research needs to be undertaken within other Trusts and in particular to appreciate how the culture and contextual factors, such as strength of team identity, then impacts incivility and the success of the intervention. All uncivil behaviour by nature involves more than one person, so in this study by focusing solely on the AHPs as targets of incivility also presents a limitation. Being able to involve the other individuals, so the consultants, would have developed the scope of the study. To examine both sides of the relationship, would have supported the techniques of the workshop intervention, as well as providing further rich and interesting data regarding incivility in a clinical setting.

A further limitation was regarding the data collection, as using different methods may have provided more insight into the prevalence of incivility (Nicholson & Griffin, 2015) and examined the organisational culture in more depth. Using methods such as surveys and observations (Braun & Clarke, 2013) would have explored the frequency and type of uncivil leadership, and its effects in a wider context than currently presented in this thesis. These methods could also have examined the area of team identity further, as a noticeable theme of the research (see section 4.2.6). Consequently, a limitation exists through the design of the intervention only focusing on individuals and not examining this team level. As identified below (see

section 8.10) the effect of the team on challenging incivility was significant in this research and would have been interesting to explore further. The understanding of this team effect presents a limitation, yet also highlights an important area within the healthcare setting for future research, as discussed below.

8.8.1 Limitations with regards to the intervention delivery and evaluation

A critical contextual factor for this study is the primary significance of the constraints and dynamic nature of conducting applied research within the operational clinical setting of an Acute Hospital Trust. This explains why most of the research on incivility within the area of health is not within a hospital setting, but instead based in academic and educational settings (Clark, 2017).

Due to these clinical and operational pressures, the intervention was limited in scope, for example a full post intervention workshop was not possible, so there was no opportunity for follow up evaluation of the intervention. Specifically, this had consequences in relation to a lower sample size that was planned in study two. During the study period it was operationally difficult to get the overall participant number of 80 AHPs to attend the intervention workshop. To achieve these numbers meant the researcher delivering the workshop seven times to maximise attendance. Undertaking a control and experimental group was also complex when accounting for shift patterns, as well as the changing operational clinical demands. As discussed above, due to operational pressures and demands, the reduced post intervention workshop was a limitation to the thesis intervention design. The timing of the research over the winter period, resulted in limited numbers of AHPs being available as they were needed operationally. As a consequence, only two workshops were organised, so a repeated measure of the survey was therefore not possible. In the workshop facilitated discussions as well as in post session feedback, the delegates reported they had initiated many successful challenging

conversations since the intervention workshop. Although this is just indicative feedback, it does suggest a positive trend. It does indicate that a further workshop could have increased the effect on confidence and resilience. Furthermore, it highlights a limitation, as in the evaluation it was not possible longitudinally to see if the increases in confidence and resilience following the intervention were still apparent. It would have also been extremely valuable to examine these measures in relation to the success of the challenging conversations the individuals had undertaken.

8.9 Further studies

As far as the author is aware this is the first study to undertake research within Physiotherapy, or indeed any Allied Health Profession to examine uncivil behaviour within a clinical operational setting. It has subsequently produced many new areas and developments for further study, as have been identified at various points throughout this chapter. There were also some main themes where future research is important and in particular with regards to patient care, also potentially critical. These themes are discussed below.

First, the relationship between incivility and patient care was of vital significance within the research. In study one, this was identified in many places, ranging from a lack of open and honest conversations, to avoidance, acting as a mediator between the patient and the consultant and also changing clinical practice when the uncivil consultant was on duty. At various points throughout the interviews, the participants openly admitted that the consequences of these situations did indeed have an impact on patient care. Such critical findings need more research and in particular, within the operational context of a hospital ward setting, as undertaken within this research.

The difference between challenging and confronting uncivil behaviour became apparent when the researcher was examining the findings and results from study one and study two. The success of the intervention could also be partially attributed to the technique being planned, rather than an instant, so in the moment confrontation. It would therefore be interesting to explore this distinction further, to examine if the participants also distinguish between these two behaviours and if they see a resulting impact on the effectiveness. The resulting success could be significantly important to how future interventions are designed and delivered.

The relationship between humour and incivility was a key area within this research and through study one, emerged as the only technique that was reportedly always successful when challenging or confronting conversations. The success of this “jokey style” (see section 4.2.11) was often attributed to not threatening the hierarchy and so the consultant’s seniority. The use of humour and how it acts to moderate the challenging process, is an interesting aspect to explore further, particularly how its success may be related to the context and culture of the organisation. The use of humour within an intervention design could also be examined and how it could build confidence by offering an alternative method of challenging.

The strength of team identity was significant throughout the research and heavily influenced the process of challenging incivility. The determination and drive to always challenge on behalf of their team, is an interesting area for further research, particularly in understanding the values behind this motivation. As identified above (see section 8.7.1) if these motives are understood then they could be used to develop other values, such as not tolerating incivility or increasing the motivation to challenge on behalf of themselves. Once the processes are understood further,

it could provide a beneficial aspect for future development of interventions in this area.

The strong professional identity of Physiotherapists was noticeable throughout the study, and how this aspect of organisational culture shaped the process of challenging. The participants would often discuss their pride in being a Physiotherapist, and this also acted as a motivation to challenge the uncivil behaviour of the consultant. Further studies could examine the values and strength of pride and how this could be used to develop confidence, as well as instil other values surrounding challenging the behaviours.

Further research needs to be conducted into the clinical specialism and the social skills of consultants, and the impact of poor social skills on the individual, teams and ultimately patient care. This could have a positive influence, as if the effect of such incivility is understood and communicated more, then perhaps the cultural acceptance that social skills are additional would be questioned. With this cultural change, then poor social skills and communication may be tolerated less, resulting in more confidence in challenging the uncivil behaviour.

8.10 The doctorate programme aims

The completion of the professional doctorate has provided an opportunity for the researcher, as a practitioner Occupational Psychologist to further enhance their theoretical and applied understanding of Occupational Psychology, through the achievement of the aims below.

- Developing Occupational Psychologists' ability to apply psychological theory to the real world, provide an evidence base for their practice, whilst also reflecting critically upon their own practice and application of psychology.

- Enabling students to identify innovative solutions to existing work-based problems and in turn make an original contribution to the field.

The evidence base was provided in both studies one and two, as well as the critical reflection in chapter seven. This reflection focused on the author's personal development and journey throughout this professional doctorate, in particular the increasing identity as an Occupational Psychologist. This was noticeable with the alignment of the author's personal, role and organisational identity (Elsey, 2016).

With regards to the aims and objectives of the doctorate, these were all met, and with reflection the importance and necessity of evidence-based practice in real world settings was particularly reinforced. Demonstration of the practical application of psychology was with the design, delivery and success of the intervention. The author has made an original contribution to the field of Occupational Psychology within the area of incivility in the workplace and this has been summarised within the contents of this chapter.

8.11 Chapter summary

This chapter outlines the key findings of the research questions, as well as satisfying the aims of the professional doctorate programme. The limitations of this research have been presented, as well as suggested research to continue examining the area of incivility, particularly within the profession of Physiotherapy and other AHPs.

More studies within an operational hospital setting need to take place, but until the implications of how incivility within a ward setting can affect patient care are fully appreciated, this is likely to be limited. Such impacts on patient care are assumed to be minimal, particularly when compared to areas such as surgery where potential loss of life, and expensive legal cases, can result in research being

prioritised. In comparison, the impact of patient care through avoidance, or lack of open patient discussions and communication, can seem trivial in comparison. Any further research also requires an investment in resources and time away from clinical operations, often difficult in the current financial pressures of the NHS.

It is ironic that Physiotherapists always put the patient first, yet by not confronting and challenging behaviour, then this consequently has a detrimental effect on the patient. If such effects were identified through more evidence-based research, then it may impact their behaviour and encourage them to deal and challenge the incivility more often. If incivility research became more widespread and the ultimate impact on patient care is understood, then it may act as catalyst to change the culture of such incivility within a hospital setting, resulting in improvements for individuals, teams as well as the patient.

The professional doctorate examined Physiotherapist experiences of incivility, the effect it had on them and how they went about challenging this behaviour. Following this a novel bespoke intervention was developed that resulted in improvements in confidence and resilience in undertaking challenging conversation in order to address incivility. This is one of only a handful of studies that have reported design and evaluative data in relation to a real-world intervention. Conducting applied intervention-based research in healthcare settings is extremely challenging, due to the working context, and it is acknowledged that this did shape the scope of this project. However, these challenges should not prevent or dissuade researchers from undertaking this important work, as it offers great value to the individuals involved and the healthcare organisations as a whole. The nature of the professional doctorate is such that it has allowed a medium term extended examination of the phenomenon of workplace incivility. This has led to identifying important future research areas

and insights for practitioners and applied researchers in planning for their own interventions.

APPENDICES

Appendix A: Study 1 - The interview schedule

Interview Schedules

Intro: Everything is confidential but please do not worry if names slip out by accident as they will be deleted from the recording and amended from the transfer. If you would like to use generic titles of pseudonyms throughout the interview, then that may be easier.

Job details

1. How long have you been in the NHS and this Trust?
2. What contact do you have with other senior leaders and also consultants - and in what context?

Leadership within the trust

3. How would you describe the Leadership within this trust?
4. Can you tell me your views on what makes a good Leader or consultant?
5. Without giving names, can you tell me about a leader or a consultant that you enjoy working with and why?
6. What sort of behaviours do you see in this person?
7. Can you tell me about a leader or a consultant who you don't enjoy working with and why?
8. What sort of behaviours do you see in this person?
9. Can you tell me about a leader or a consultant who is dominant and disrespectful?
10. What sort of behaviours do you see in this person?
11. Do you enjoy working with them and why?
12. Do you admire them and why?

Dominant and disrespectful leadership and the individual

13. Looking in particular at the leaders and/or consultants who are dominant and disrespectful - why do you think they behave in the ways you describe?
14. What contact do you have with such leaders or consultants?
15. When you are working with them how does it makes you feel?
16. Can you think of any examples?
17. Does it affect your behaviour and how?
18. How does it affect your job performance?
19. How does it affect you and your confidence, motivation and or job satisfaction?
20. Do you avoid contact with his person - how?

Dominant and disrespectful leadership and the team and culture

- 21. How does this affect your team?
- 22. How do your team react to this behaviour?
- 23. How do others behave in their company?
- 24. Why do you think no one challenges them?

How would like to change

- 25. How would you like to behave in their company?
- 26. How would you like others to behave in their company?
- 27. Why do you think others let them behave in this way?
- 28. Is this behaviour common in your organisation/their culture/your profession?

Appendix B: Study 1 - Participant consent form for recording interviews



Faculty of Health & Life Sciences

Project title: Addressing the influence of dominant leaders upon employees

Principal Investigator: Frances Dodd

I hereby confirm that I give consent for the following recordings to be made:

Recording	Purpose	Consent
Voice recordings	For the creation of a written transcript on the influence of dominant leaders upon employees, for use in a qualitative analysis.	

Clause A: I understand that the recording(s) may be published in an appropriate journal/textbook or on an appropriate Northumbria University webpage. My name or other personal information will never be associated with the recording(s). I understand that I have the right to withdraw consent at any time prior to publication, but that once the recording(s) are in the public domain there may be no opportunity for the effective withdrawal of consent.

Tick or initial the box to indicate your consent to Clause A ☐

Signature of participant..... Date.....

Signature of researcher..... Date.....

Appendix C: Study 1 - Participant information sheet

PARTICIPANT INFORMATION

The purpose of this information sheet is to provide you with sufficient information so that you can then give your informed consent. It is thus very important that you read this document carefully and raise any issues that you do not understand with the investigator.

Name of Researcher: Frances Dodd

Name of Supervisor: Neill Thompson

Project Title: Addressing the influence of dominant leaders upon employees

1. What is the purpose of the project?

This research project aims to examine the influence of dominant, yet successful leaders upon individuals within the reality and complexities of the National Health Service (NHS). Leadership will be discussed as a complex process, so rather than looking just at leaders; the context of the behaviour, as well as their followers will also be examined. Previously the researcher has conducted interviews, and this workshop intervention was developed to address how the Individual can successfully manage the dominant leader in their daily work.

2. Why have I been selected to take part and what are the exclusion criteria?

You have been selected as part of a group who were emailed about the opportunity.

3. What will I have to do?

You will be asked to complete three questionnaires before the workshop and then another one afterwards. If there are any questions which you do not wish to answer you do not have to do so. The questionnaires should only take about 5 to 10 minutes to complete.

4. Will my participation involve any physical discomfort? You will not experience any physical discomfort as a result of participation in the study. However, if you do feel uncomfortable then you may take a comfort break at any time in the workshop.

5. Will my participation involve any psychological discomfort or embarrassment?

No psychological discomfort or embarrassment is expected as a result of being a participant in this study. If you do become uncomfortable or upset during participation then you may decline to answer any question, or withdraw from the study completely. During participation you may also take comfort breaks or stop participation completely. If after participation you begin to feel uncomfortable with the use of your data you may also withdraw by emailing the researcher within one month of participation.

6. Will I have to provide any bodily samples (i.e. blood, saliva)?

No, bodily samples will be taken as part of participation in the study

7. How will confidentiality be assured and who will have access to the information that I provide?

Upon signing a consent form you will be provided with a participant number which will be the only identifier for your data after this point. Consent forms and data will be stored separately not to allow identification of participant's data. During data transcription any names of people or places will be removed or replaced with pseudonyms. At the start of the questionnaire, you will be asked about your job role, although this will be kept anonymous. Once the project has been completed all documentation will be handed into Northumbria University stored securely and then destroyed.

8. Will I receive any financial rewards / travel expenses for taking part?

No monetary or other reward or compensation will be given as part of participation in the study.

9. How can I withdraw from the project?

You can withdraw from the project before participation and if you agree to participate, you may still withdraw during the interview by telling the Researcher. If you wish to withdraw from the project after participation you can email the researcher, within one month of participation and quote your participation number as given on the consent form: f.dodd@yorks.ac.uk. Or email the supervisor Neill Thompson; Neill.Thompson@northumbria.ac.uk. Upon withdrawal, all data held will be destroyed by the researcher, including in the consent form, audio and transcription.

10. If I require further information who should I contact and how?

If you require any further information on the project please email the researcher at; f.dodd@yorks.ac.uk. or the supervisor Neill Thompson; Neill.Thompson@northumbria.ac.uk. If you have any concerns about research please contact the Department of Psychology Ethics Chair (postgraduate) at andriy.myachykov@northumbria.ac.uk

If you have any concerns or worries concerning this research or if you wish to register a complaint, please direct it to the Department of Psychology Ethics Chair (Postgraduate) at the address below, or by Email: andriy.myachykov@northumbria.ac.uk

The data collected in this study will be used for a Occupational Psychology Professional Doctorate Thesis. It may also be published in scientific journals or presented at conferences. Information and data gathered during this research study will only be available to the research team named above, and the Postgraduate Ethics Chair (Andriy Myachykov). Should the research be presented or published in any form, all data will be anonymous (i.e. your personal information or data will not be identifiable).

All information and data gathered during this research will be stored in line with the Data Protection Act and will be destroyed 6 months following the conclusion of the study. If the research is published in a scientific journal it may be kept for longer before being destroyed. During that time the data may be used by members of the research team only for purposes appropriate to the research question, but at no point will your personal information or data be revealed. Insurance companies and employers will not be given any individual's information, samples, or test results, and nor will we allow access to the police, security services, social services, relatives or lawyers, unless forced to do so by the courts.

This study and its protocol have received full ethical approval from the Department of Psychology Ethics Committee (Postgraduate) in accordance with the School of Health and Life Sciences Ethics Committee. If you require confirmation of this please contact the Chair of this Committee, stating the title of the research project and the name of the researcher:

Dr Andriy Myachykov

Chair of Department of Psychology Ethics Committee (Postgraduate)

Northumbria University

Newcastle upon Tyne NE1 8ST

Appendix D: Study 1 - Participant consent form



Faculty of Health & Life Sciences

Project Title: Addressing the influence of dominant
upon employees

Principal Investigator: Frances Dodd

Participant number:

*please tick or initial
where applicable*

I have carefully read and understood the Participant Information Sheet.	<input type="checkbox"/>
I have had an opportunity to ask questions and discuss this study and I have received satisfactory answers.	<input type="checkbox"/>
I understand I am free to withdraw from the study at any time, without having to give a reason for withdrawing, and without prejudice.	<input type="checkbox"/>
I agree to take part in this study.	<input type="checkbox"/>
I would like to receive feedback on the overall results of the study at the email address given below.	<input type="checkbox"/>
Email address.....	

Signature of participant.....
Date.....

(NAME IN BLOCK
LETTERS).....

Signature of researcher.....
Date.....

(NAME IN BLOCK
LETTERS).....

Appendix E: Study 1 - Participant debrief sheet

PARTICIPANT DEBRIEF

Name of Researcher: Frances Dodd

Name of Supervisor: Neill Thompson

Project Title: Addressing the influence of dominant leaders upon employees

1. What was the purpose of the project?

This research project aims to examine the influence of dominant, yet successful leaders upon individuals within the reality and complexities of the National Health Service (NHS). Leadership will be discussed as a complex process, so rather than looking just at leaders; the context of the behaviour, as well as their followers will also be examined. In order to gain further understanding the data collected will be analysed through thematic analysis to determine any trends and then an intervention will be developed.

2. How will I find out about the results?

If you have selected to receive results on the consent form then you will be emailed by the researcher upon completion of the project. A brief of the overall findings will also form part of the second part of this project which is the practical intervention.

3. Have I been deceived in any way during the project?

You have not been deceived at any point during this study

4. If I change my mind and wish to withdraw the information I have provided, how do I do this?

If you wish to withdraw from the project you can email the researcher, within one month of participation and quote your participation number as given on the consent form: f.dodd@yorks.ac.uk. Or email the supervisor Neill Thompson; Neill.Thompson@northumbria.ac.uk. Upon withdrawal, all data held will be destroyed by the researcher, including in the consent form, audio and transcription.

If you have any concerns or worries concerning this research or if you wish to register a complaint, please direct it to the Department of Psychology Ethics Chair (Postgraduate) at the address below, or by Email: andriy.myachykov@northumbria.ac.uk

The data collected in this study may also be published in scientific journals or presented at conferences. Information and data gathered during this research study will only be available to the research team identified in the information sheet, and the Ethics Chair. Should the research be presented or published in any form, all data will be anonymous (i.e. your personal information or data will not be identifiable).

All information and data gathered during this research will be stored in line with the Data Protection Act and will be destroyed XX months following the conclusion of the study. If the research is published in a scientific journal it may be kept for longer before being destroyed. During that time the data may be used by members of the research team only for purposes appropriate to the research question, but at no point will your personal information or data be revealed. Insurance companies and employers will not be given any individual's information, samples, or test results, and nor will we allow access to the police, security services, social services, relatives or lawyers, unless forced to do so by the courts.

This study and its protocol have received full ethical approval from the Department of Psychology Ethics Committee in accordance with the School of Health and Life Sciences Ethics Committee. If you require confirmation of this please contact the Chair of this Committee, stating the title of the research project and the name of the researcher:

Appendix F: Pre-defined a-priori themes

1.0 Job details

- 1.1 How long have you been in the NHS and this Trust?
- 1.2 What contact do you have with other senior leaders and also consultants – and in what context?

2. Leadership within the trust

- 2.1 Leadership within this trust?
- 2.2 What makes a good Leader or consultant?
- 2.3 What sort of behaviours do you see in this person?
- 2.4 Leader or a consultant who you don't enjoy working with and why?
- 2.5 What sort of behaviours do you see in this person?
- 2.6 Leadership dominant and distrustful
- 2.7 Can you tell me about a leader or a consultant who is dominant and disrespectful?
- 2.8 What sort of behaviours do you see in this person?
- 2.9 Do you enjoy working with them and why?
- 2.10 Do you admire them and why?

3. 0 Dominant and disrespectful leadership and the individual

- 3.1 Why do you think they behave in the ways you describe?
- 3.2 When you are working with them how does it makes you feel?
- 3.3 How does it affect you?
- 3.4 Do you avoid contact with his person - how?

4.0 Team and culture

- 4.1 How does this affect your team?
- 4.2 How do others behave in their company?
- 4.3 Why do you think no one challenges them?

5.0 How would like to change

5.1 How would you like to behave in their company?

5.2 Why do you think others let them behave in this way?

5.3 Is this behaviour common in your organisation/their culture/your profession?

Appendix G: Template Analysis – Template 1

Length of service

1. Frequency of senior leader contact

2. Communication

- 3.1 authentic leader - not duping – smiling
- 3.2 unwilling to give praise- risk losing power
- 3.3 different communication styles- authentic
- 3.4 Support and setting boundaries
- 3.5 putting them at ease early on
- 3.6 problems with communication
- 3.7 unclear communication
- 3.8 Communication method
 - 3.8.1 - meetings
 - 3.8.2 - emails
- 3.9 change in communication frequency
- 3.10 MDT
- 3.11 Not listening
- 3.12 Held hand up example

3. Challenging the behaviours

- 4.1 standing up to the antagonist – unsuccessfully
- 4.2 Tackling on behalf of others
- 4.3 positive feeling after successful challenge - short term win- no repeat challenge
- 4.4 challenging the behaviour - how doing effectively- process
 - 4.4.1 Challenging – appropriate
- 4.5 not questioning - like that with everyone
- 4.6 Team morale
- 4.7 How would like to challenge

4.8 consultant challenging other consultants

4.9 Time to challenge - thinking about it

4.10 Feeling disrespectful to challenge

4.11 Conflict

4.12 Lost the ability to challenge

5 What is feels like to work with these people

5.1 impact of behaviours

5.2 Frightened

5.3 poor behaviour is a result of feeling they are not good at their job

5.4 negative behaviour - spiky - back handed compliments

5.5 negative behaviour triggered of poor coping

5.6 distinction between dominant or disrespectful

5.7 negative behaviour - inflexible, barrage

5.8 Changes in behaviour

5.9 Coping strategies

5.10 made to feel foolish-talked down to

5.11 made to feel worthless- poor communication style

5.12 Avoidance

5.13 disrespectful

6. Respect

6.1 admiration

6.1.1 Anointed with praise

6.2 Respectful leadership

6.3 Disrespect on behalf of AHP to leaders

6.4 Lack of respect

6.5 relationship - mutually beneficial

6.6 Praise via patients

6.7 Appreciating praise despite consultant being difficult

6.8 Parent child

- 6.9 Admire
- 6.10 female
- 6.11 Really thought why behave that way
- 6.12 Rational so can cope and treat with respect

7. why they behave that way

- 7.1 excuses
- 7.2 Coping strategy
- 7.3 Excuses as good with patients
- 7.4 Respect as delivers
- 7.6 Classic style consultant

8.0 Culture of leadership

- 8.1 Leaders Clinically good - yet not good at other leadership
- 8.2 difference between leaders and consultants
- 8.3 Poor leader competences
- 8.4 previous management strategies
- 8.5 Positive leadership influence
- 8.6 Line Manager Support
- 8.7 Good leader competencies
- 8.8 bullying

8.9 Challenging Physio's practice

- 9.0 Need to know my place
- 9.1 Respectful challenge
- 9.2 Hierarchy
 - 9.2.1 God - like
- 9.3 Power
- 9.4 Fireproof and untouchable
- 9.5 Showing their dominance

10.0 Patient care

10.1 Mistakes

11.0 Communication - made to feel foolish

11.1 Talk down to

11.1.1 Make me feel small and not worthy

11.2 Think highly of me, yet not tell me and make me feel small and not worthy

11.3 Communication via patients

11.4 Making excuses for them

11.5 Consultant behaves with other consultants

Appendix H: Changes from Template 2 to 3 and then 3 to 5

Changes from Template 1 to 3 – following independent scrutiny of coding after the first 8 scripts

First level theme	Second Level theme	Third Level sub-code
1. Length of service		
2. Frequency of senior leader contact		
3. Communication	3.1 Authentic leader - not duping – smiling	
	3.2 unwilling to give praise-risk losing power	
	3.3 different communication styles-authentic	
	3.4 Support and setting boundaries	
	3.5 putting them at ease early on	
	3.6 problems with communication	
	3.7 unclear communication	
	3.8 Communication method	3.8.1 Meetings

		3.8.2 Emails
	3.9 change in communication frequency	
	3.10 MDT	
	3.11 Not listening	
	3.12 Held hand up example	
4. Challenging the behaviours	4.1 Standing up to the antagonist – unsuccessfully	
	4.2 Tackling on behalf of others	
	4.3 positive feeling after successful challenge - short term win- no repeat challenge	
	4.4 Challenging the behaviours – how doing effectively – process of challenging	4.4.1 Appropriate to challenge - target responding with negative behaviours- intent to irritate
	4.5 not questioning - like that with everyone	
	4.6 Team morale	
	4.7 How would like to challenge	
	4.8 consultant challenging	

	other consultants	
	4.9 Time to challenge - thinking about it	
	4.10 Feeling disrespectful to challenge	
	4.11 Conflict	
	4.12 Lost the ability to challenge	
5. What is feels like to work with these people	5.1 impact of behaviours	
	5.2 Frightened	
	5.3 poor behaviour is a result of feeling they are not good at their job	
	5.4 negative behaviour - spiky - back handed compliments	
	5.5 negative behaviour triggered of poor coping	
	5.6 distinction between dominant or disrespectful	
	5.7 negative behaviour-	

	inflexible, barrage	
	5.8 Changes in behaviour	
	5.9 Coping strategies	
	5.10 Made to feel foolish talked down to	
	5.11 made to feel worthless- poor communication style	
	5.12 Avoidance	
	5.13 disrespectful	
6. Respect	6.1 admiration	6.1.1 Anointed with praise
	6.2 Respectful leadership	
	6.3 Disrespect on behalf of AHP to leaders	
	6.4 Lack of respect	
	6.5 Relationship - mutually beneficial	
	6.6 Praise via patients	
	6.7 Appreciating praise	

	despite consultant being difficult	
	6.8 Parent child	
	6.9 Admire	
	6.10 Female	
	6.11 Really thought why behave that way	
	6.12 Rational so can cope and treat with respect	
7. Why they behave that way	7.1 Excuses	
	7.2 Coping strategy	
	7.3 Excuses as good with patients	
	7.4 Respect as delivers	
	7.5 Classic style consultant	
8. Culture of leadership	8.1 Leaders Clinically good - yet not good at other leadership	
	8.2 Difference between leaders and consultants	

	8.3 Poor leader competences	
	8.4 Previous management strategies	
	8.5 Positive leadership influence	
	8.6 Line Manager Support	
	8.7 Good leader competencies	
	8.8 Bullying	
9. Challenging Physio's practice	9.1 Need to know my place	
	9.2 Respectful challenge	
	9.3 Hierarchy	9.3.1 God – like
	9.4 Power	
	9.5 Fireproof and untouchable	
	9.6 Showing their dominance	
10. Patient care	10.1 Mistakes	

11. Communication - made to feel foolish	11.1 Talk down to	11.1.1 Make me feel small and not worthy
	11.2 Make me feel small and not worthy	
	11.3 Think highly of me, yet not tell me	
	11.3 Communication via patients	
	11.4 Making excuses for them	
	11.5 Consultant behave with other consultants	

Template Analysis – Tracked changes to Template

	Changes
Changes from template 1 to 3 after 8 interviews	<ul style="list-style-type: none"> • 3.1 Authentic leader - not duping – smiling – move to 3.2.1 as more suitable as a sub code under different communication styles • 3.3 different communication styles- authentic removed word authentic as now a sub code • 3.4 Support and setting boundaries – now sub code under communication methods • 3.7 unclear communication – moved to become a sub code under problems with communication • 3.9 change in communication frequency – clarified to “and/or” frequency • 3.11 Not listening – moved to a sub code under communication method • 3.12 Held hand up example – moved to a sub code under communication method • 4.4.1 Appropriate to challenge - target responding with

	<p>negative behaviours- intent to irritate – reword to Challenging – appropriate</p> <ul style="list-style-type: none"> • 4.9 Time to challenge - thinking about it changed to sub code 4.4.2 • 4.11 Conflict removed as occurred in other codes • 5.9 Coping strategies - change to be a sub code of changes in behaviour • 5.13 disrespectful move to be a sub code of Distinction between dominant or disrespectful • 6.1 admiration – defined by adding in “intention to do the right thing” • 6.2 Respectful leadership added “and respect each other’s professional boundaries” • 6.9 Admire – added in “or respect” • 6.10 Female defined by changing to “Respect for women in consultancy leadership role” • 7.4 Respect as delivers added in “and dedicated” • 9.3 Hierarchy added in sub code of 9.3.2 Throne
Changes in template 3 to 4 after reviewer feedback and researcher review and discussion	<ul style="list-style-type: none"> • 2.0 Frequency of senior leader contact - added in four sub themes - to make less vague: <ul style="list-style-type: none"> ○ Within MDT’s ○ Daily basis or share an office ○ Quite infrequently ○ Quite frequently but not daily • 3.0 Communication section changed to three sections to avoid crossover and make clearer, all second level themes under these: <ul style="list-style-type: none"> ○ Positive communication ○ Situations and circumstances of communication ○ Poor communication • 3.8 Communication method changed to situations and circumstances of communication • 4.4.1 challenging appropriate moved into 4.4 as not distinct to be on own

	<ul style="list-style-type: none"> • 5.3 poor behaviour is a result of feeling they are not good at their job removed as quote more about patient communication • 5.4 Negative behaviour - moved to other negative category to avoid duplication • 5.6.1 put disrespectful in theme 5.6 as not warrant another sub section • 5.8.1 Coping strategies – move to separate theme and changed title • 5.10 Made to feel worthless – poor communication style moved and split quotes to communication style and some to not respecting Physio practice • 6.8 Parent child – moved from respect to section 5 “what is feel like to work with these people” as fits more • 9.3 removed this, as only one comment and fitted into god-like theme • 9.4 added in Bullying theme into this section • 11.4 Moved “making excuses for them” to why they behave that way
<p>Template 4 to 5</p> <p>These changes occurred in transcripts 8 to 20</p> <p>New themes emerged which then meant transcripts 1 to 8 needed to be recoded to ensure themes had not been missed.</p>	<ul style="list-style-type: none"> • 3.0 revised categories of communication to version 5 • 4.1 changed title as too specific to “standing up to the leader – yet behaviour stays the same or reverts back” • 4.2 Tackling on behalf of others to “Tackling leader on behalf of your team” • 4.4.2. Time to challenge - thinking about it was removed – was too specific • 4.3 Challenging the behaviours – how doing effectively – process of challenging – simplified to “Challenging the behaviour – positive results” • 4.4 Team morale – did not fit in other interviews, so removed. • 4.5 Added “Challenging in a jokey way – yet successful”. • 4.6 How would like to challenge – made more specific by adding “How individual would like...” • 4.9 Added “not have the energy to challenge” as emerged as a theme • 4.10 Added “not challenge as just deal with it” • 4.11 Added “Challenging Physiotherapy and the Physio’s practice” • 4.12 Conflict changed to avoiding conflict – make clearer • 4.13 Lost the ability to challenge – removed as too specific to one interview

	<ul style="list-style-type: none"> • 5.4 changed to include stress “Changes in behaviour or more stressful working with them” • 5.5. Changed to “not feel valued - made me feel foolish” • 5.7 Changed to “Coping mechanisms when working with such leaders” • 5.8 changed to “Made me more reflective of own behaviours” • 5.9 Added “Enjoyment” as important to have theme of positive aspect • Removed “Poor behaviour as a result of feeling they are not good at their job” as repetitive and included in another sub theme • Removed “Negative behaviour – spiky – back handed compliments” as too specific • Removed “Negative behaviour triggered of poor coping” as too specific and covered elsewhere • Removed 5.5.1 as repetitive to include disrespectful again • 5.10 removed to communication style theme • Removed “negative behaviour – inflexible, barrage” as too specific and negative behaviour included elsewhere • Removed 6.1.1 as only referred to one interview • 6.6 praise via parents removed as only referred to one example • Removed “Appreciating praise despite consultant difficult” as too specific to one example • Removed “Parent child” as too specific to one example • 6.9 changed admire or respect to “positive admiration or respect” • 6.8 added in “professional respect” • Removed 6.10 “respect for women in consultancy leadership role”, as not emerge as a theme • Removed “Really thought why behave that way” as too specific • Removed “Rational so can cope and treat leaser with respect” as too specific to one interview • 7.1 excuses reworded to “explain behaviour by various
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	<p>ways” as a later theme that emerged</p> <ul style="list-style-type: none"> • 7.2 Coping strategy removed as covered elsewhere • 7.3 reworded from 7.3 to “Excuse behaviours as good with patients and clinical expertise” as later theme • 7.4 removed “Respect - delivers and dedicated” as repetitive • Added in “Lack of governance” as later theme to emerge • 7.5 Added in Stress as them as emerged in later interviews • 8.4 reworded to included culture and resulting strategies • 8.8 Teamwork added as theme to emerge from later interviews • 9. Hierarchy became a theme rather than “Challenging Physio’s practice, as overlap with other themes • 9.1 godlike into this hierarchy • 9.2 Power into hierarchy • 9.3 Showing their dominance came through later • 9.4 added old school consultant • 10.0 added two themes about a good leader or consultant and a poor leader or consultant • 11.0 Communication - made to feel foolish section overlapped so moved into theme of communication and respect
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Appendix I: Template 5

(**Length of service** - take out as descriptive rather than theme)

1.0 Frequency of senior leader contact

- 1.1 Within MDT's
- 1.2 Daily basis or share an office
- 1.3 Quite infrequently
- 1.4 Quite frequently but not daily

2.0 Communication

- 2.1 positive communication
- 2.2 Situations and circumstances of communication
 - 2.2.1 Meetings
 - 2.2.2 Emails
- 2.3 change in communication and or frequency
- 2.4 Communication via patients
- 2.5 MDT
- 2.6 Poor communication
- 2.7 problems with communication - examples of
- 2.8 unclear communication
- 2.9 Not listening
- 2.10 Make me feel small and not worthy
- 2.11 Think highly of me, yet not tell me

3.0 Challenging the behaviours

- 3.1 standing up to the leader - yet behaviour stays same or reverts back
- 3.2 Tackling leader on behalf of your team
- 3.3 challenging the behaviour positive results
- 3.4 not questioning - like that with everyone
- 3.5 Challenging in a jokey way - yet successful

- 3.6 How individual would like to challenge behaviour
- 3.7 consultant challenging other consultants
- 3.8 Feeling disrespectful to challenge
- 3.9 Not have the energy to challenge
- 3.10 not challenge as just deal with it
- 3.11 Challenging Physiotherapy and the Physio's practice
- 3.12 Avoiding conflict

4.0 What is feels like to work with these leaders

- 4.1 impact of behaviours
- 4.2 Frightened
- 4.3 distinction between dominant or disrespectful
- 4.4 Changes in behaviour or more stressful working with them
- 4.5 not feel valued - make me feel foolish
- 4.6 Avoidance
- 4.7 Coping mechanisms when working with such leaders
- 4.8 Made me more reflective of own behaviour
- 4.9 Enjoyment

5.0 Respect

- 5.1 Admiration - intention to do the right thing
- 5.2 Respectful leadership and respect each other's professional boundaries
- 5.3 Disrespect on behalf of AHP to leaders
- 5.4 Lack of respect
- 5.5 Relationship - mutually beneficial
- 5.6 Positive admiration or respect
- 5.7 Respect - delivers and dedicated
- 5.8 Professional respect

6.0 Why they behave that way

- 6.1 Explain behaviour by various ways
- 6.2 Excuse behaviours as good with patients and clinical expertise
- 6.3 Classic style consultant
- 6.4 Lack of governance
- 6.5 Stress

7.0 Workplace culture and culture of leadership

- 7.1 Leaders clinically good - yet not good at other leadership
- 7.2 Difference between leaders and consultants
- 7.3 Poor leader competencies
- 7.4 Previous management culture and resulting strategies
- 7.5 Line Manager Support
- 7.6 Good leader competencies
- 7.7 Bullying
- 7.8 Teamwork

8.0 Hierarchy

- 8.1 God - like
- 8.2 Power
- 8.3 Showing their dominance
- 8.4 Old school consultant

9.0 Patient care

- 9.1 Mistakes

A good leader or consultant (take out as descriptive rather than theme)

A poor leader or consultant (take out as descriptive rather than theme)

Appendix J: Template 6

1.0 What is feels like to work with these leaders

- 1.1 impact of consultants' inconsistent behaviour
- 1.2 stress and rumination working with them
- 1.3 coping strategies
- 1.4 avoidance
- 1.5 frightened
- 1.6 made me more reflective of own behaviour
- 1.7 enjoyment working with some of the consultants

2.0 Hierarchy

- 2.1 Hierarchy on a day to day basis
- 2.2 God – like
- 2.3 Old school consultants
- 2.4 Power

3.0 Why they behave that way

- 3.1 Explain behaviour by various ways
- 3.2 Excuse behaviours as clinical expertise
- 3.3 Classic style consultant
- 3.4 Lack of governance
- 3.5 Stress

4.0 Patient Care

- 4.1 Impact of the consultant on the ward
- 4.2 Role of mediator between consultant and patient
- 4.3 Patient care with examples of good consultants and leadership
- 4.4 Incivility when the physiotherapist is not present

5.0 Workplace culture and culture of leadership

- 5.1 Previous management culture and resulting strategies
- 5.2 Relationship between leadership and culture of the workplace
- 5.3 Leaders clinically good – yet not good at other leadership
- 5.4 Bullying
- 5.5 Teamwork

6.0 Challenging the behaviours

- 6.1 Feeling disrespectful to challenge
- 6.2 Not appropriate to challenge
- 6.3 Not challenge as just deal with it
- 6.4 Justification of the uncivil behaviour so not worth challenging
- 6.5 Not have the energy or skills to challenge
- 6.6 Challenging on behalf of their team and others
- 6.7 Challenging on behalf of consultants
- 6.8 Challenging on behalf of their profession and professional pride
- 6.9 Standing up to the leader – yet the behaviour stays the same or reverts back
- 6.10 Challenging the behaviour – positive results
- 6.11 Challenging in a jokey way – yet successful
- 6.12 How individual would like to challenge behaviour

Appendix K: Workshop materials



Difficult/challenging conversations

Frances Dodd
York St John University



Think of a difficult conversation that:

- Went well?
- Went badly?
- What was the difference?

Today

- What is a difficult/challenging conversation?
- Techniques and 5 steps to give you confidence.
- Work through an example.
- What to do when it just doesn't work!

Do we have to have them at all?

- Can we be so overwhelming pleasant that ends up fine?
- Is this the answer?
- Similar to pulling a pin on a hand grenade ...

Turn from hand grenade business!

- Turn from hand grenade business to a **learning conversation**.
- Deal with tough problems with decency and integrity.

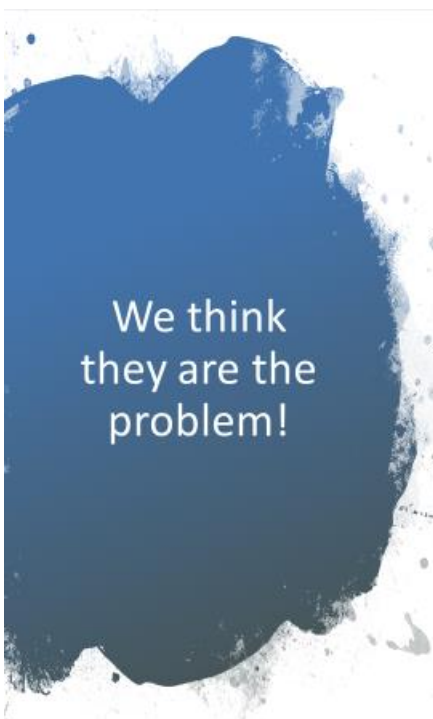
The problem

- Need to understand what is being said and what NOT being said.
- What people involved are thinking and feeling but NOT saying.

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Each difficult
conversation
is really three
deeper
conversations

- The “What happened” conversation.
- The “Feelings/emotions” conversation.
- The “Identity” conversation.

A large, irregular blue ink blot with a textured, watercolor-like appearance, featuring various shades of blue and some white highlights, positioned on the left side of the slide.

We think
they are the
problem!

- We don't see ourselves as problem as ...what we say makes sense.
- But ...what other person is saying also makes sense!
- Example of Jack and Michael.

Step 1: Walk through three conversations

1. What's happened – truth, intentions, blame
2. Understand emotions
3. Ground your identity

Go into conversation knowing what heightened emotion is yours.

Step 1. What's happened: Truth

- We assume it's a factual matter but.....
- What happened and who is to blame.
- Conflicting perceptions, interpretations and values of the facts and what is important.

Move away from delivering messages/statements to..... asking questions and exploring how each person is making sense of the world.

To offer our views as perceptions, interpretations, and values – not as “the truth”.

Step 1. What’s happened: Intentions

- Second part of “what’s happening” conversation is over intentions.
- We assume we know the intentions of others.
- Yet intentions are invisible. We assume them from people’s behaviour.
- Our view of others intentions (and theirs of ours) are so important in difficult conversations - leaping to conclusions can be a disaster.

Step 1. What's happened: Blame

- Third error in what's happening – blame.
- Talking about blame – produces disagreement, denial and little learning. Energy goes into defending ourselves.
- Distracts us from exploring why things went wrong and how we can correct them going forwards.

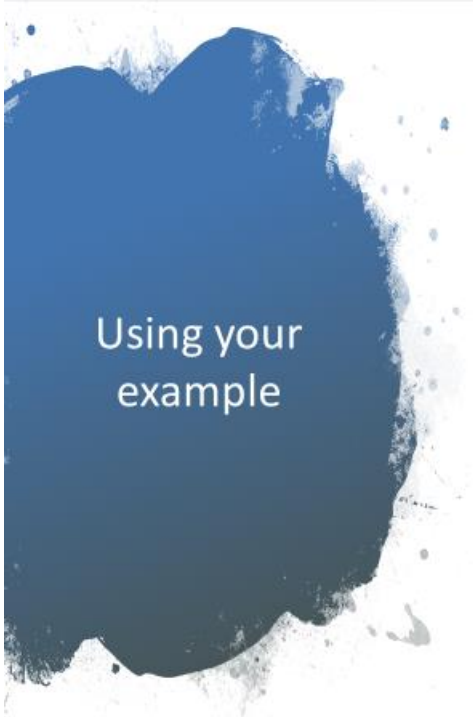
We therefore have different
information and interpretations

- So need to move to curiosity to find out.....
- Embrace both stories.



Using Jack/ Michael
example and your
own example

- What's happened :
 - Truth
 - Intentions
 - Blame



Using your
example

- Practice walking
through the first of the
three conversations:
- **1. What's happened –
truth, intentions,
blame**
- 2. Understand
emotions
- 3. Ground your identity

The Emotions/Feelings conversation

- Feelings matter - often at the heart of difficult conversations.
- Make it difficult to listen.
- Feelings are normal and natural.
- Your feelings are as important as theirs.

The Identity conversation

- Difficult conversations threaten or challenge our identity.
- Become aware of your identity and sensitivities.
- What are the triggers for you?



Jack/Michael example

Using your example:

- Practice walking through the next of the three conversations:
 - Understand emotions
 - Ground your identity



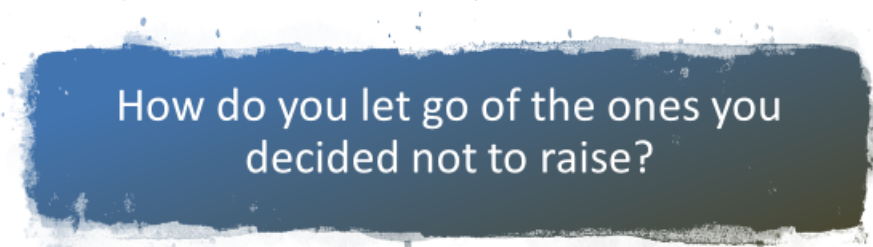
Step 2: When to raise it and when to let go

- Can't have ever difficult conversation you come across....
- How do you decide?



Does the goal
of the
conversation
make sense?

- Work through the three conversations – feelings, identity issues and possible gaps in your perceptions.
- Better basis for deciding.
- It is not worth a difficult conversation if goal not makes sense.
 - Is the real conflict inside you?
 - Is better way to address than talking about it?



How do you let go of the ones you
decided not to raise?

- Changing your mind-set or “reframing” can help reduce the damage done to you.
- Martin Seligman (1998) “learned optimism” shows when people view difficulties as temporary and not their fault – protects their mental, physical health and increases resilience.

Disney example

- Cast members taught that 99% of guests nice.
- 1% who are angry or rude.
- Imagine all awful experiences that brought this on – so broken down car etc.
- Don't take personally and also temporary.

Hope for the best – expect the worst

- Happiness reflects the difference between what you expect “v” what you get in life.
- Keep your expectations for their behaviour low but believe you will be fine when over.
- Then not surprised or upset by behaviour.

Reframing strategies

Putting on a protective jacket!

- Build pockets of Safety, support and sanity.
- Works best when join forces with colleagues.
- Get comfort and calm from others and bond together.
- Humour is a weapon and shield. Framing as funny, absurd or ridiculous can dampen the damage. (Martin, 2010).

More Reframing strategies...

- Rise above it – Michelle Obama “when they go low – we go higher.”
- Develop sympathy for the devil – even if not deserve to be let off.
- Forgiving them will bolster feelings that you are master of your own fate.

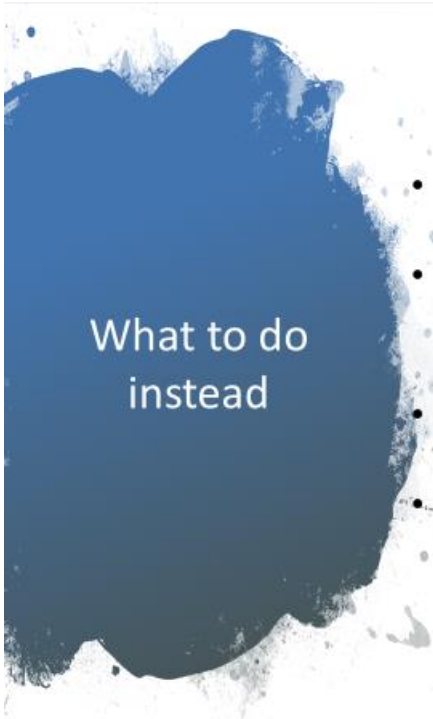


Using an example

- Would any of these reframing techniques work and when?
- Do you already use any?
- Are they effective?


Step 3: Getting started from the third story

- Typically – launch from our story where most conversations fail as implies a judgement about the other personso provokes a defensive response.
- Our story invariably says they are the problem.
- Can you think of an example where this happened?



What to do instead

- Instead, start conversation from perspective of "third story".
- Describe the problem as the difference between your stories.
- Include both viewpoints as legitimate part of the discussion.
- Invite them to join you as a **partner** in sorting out the situation together.



Invisible "third story."

- Like a mediator or marriage counsellor.
- No right, no wrong, not better or worse – just different - so an invisible "third story."
- So moving from a battle of messages to a learning conversation

Step 4: Explore their story and yours

Explore where each story comes from	"My reactions here probably have a lot to do with my experiences in a previous job"
Share the impact on you	"I don't know whether you intended this, but I felt extremely uncomfortable when..."
Take responsibility for your contribution	"There are a number of things I've done that made this situation harder...."
Describe emotions/feelings	"I'm anxious about bringing this up, but at the same time, it's important to me that we talk about it..."
Reflect on the identity issues	"I think the reason this subject gets me is that I don't like thinking of myself as someone who..."

As you share your stories – the three conversations offer a useful path to explore.



This is WHAT
to talk about


- Now look at HOW to talk about it

Listening

- Listen to them – helps them listen to you. Be curious.
- Techniques that can help you show that care and concern include:
 - Asking open questions
 - Asking for more concrete information
 - Asking questions that explore the three conversations
 - Avoid questions that are actually statements. Do not cross-examine the other!
 - Paraphrasing to clarify and check your own understanding
 - Acknowledge the power and importance of the other person's feelings, both expressed and unexpressed.

The three conversations provide fertile ground for curiosity!

- Can you say a little more about how you see things?
- What information might you have that I don't?
- How do you see it differently?
- What impact have my actions had on you?
- Can you say a little more about why you think this was my fault?
- Were you reacting to something I did?
- How are you feeling about all of this?
- Say more about why this is important to you?
- What would it mean to you if that happened?



Expression: speak for yourself

- Recognise your views/feelings are no less (and no more) important.
- Saying explicitly what is most important to you.
- Share the information, reasoning and experience behind your views.
- **Try not too...**
- Present your views as if they were the one-and-only truth.
- Use exaggerations such as "You always," or "You never."

Reframe!

- You can reframe anything! To move towards a learning conversation

Reframe from....	To this.....
Truth	Different stories
Accusations	Intentions and impact
Blame	Contribution
Judgements/characterisations	Feelings
What's wrong with you	What's going on for them

Conversations with different groups and levels

- Based on these techniques...how approach?
- Discuss and suggestions?

Step 5: Problem solving for the future.

- But still need to decide how to go forward
- Gather info and test perceptions and thinking of options to meet both sides.
- Invent options/consider alternatives.
- It takes time.....most conversations are not one single conversation but series.

Putting all together



A challenging conversation checklist - for participants to take away after the workshop. Blank sheets provided for participants to work through their own examples

Step one: Prepare by walking through the three conversations
<p>1. Sort out What Happened.</p> <p>Truth - where does your story come from – information, past experiences, rules? Theirs?</p> <p>Intention – what impact has this situation had on you? What might their intentions have been?</p> <p>Blame – what have you each contributed to the problem?</p> <p>2. Understand Emotions -</p> <p>explore your emotional footprint, and the bundle of emotions you experience</p> <p>3. Ground your identity</p> <p>What's at stake for you about you? What do you need to accept to be better grounded?</p>
Step two: Check your purpose and decide whether to raise the issue
<p>Purposes: What do you hope to accomplish by having this conversation? Shift your stance to support learning. Sharing and problem-solving.</p> <p>Deciding – is this the best way to address the issue and achieve the purposes? Is the issues really embedded di your identity conversation? Can you affect the problem by changing your contributions? If you don't raise it what can you do to help yourself let it go?</p>
Step three: Start from the third story
<p>1. Describe the problem as the difference between your stories. Include both viewpoints as a legitimate part of the discussion.</p> <p>2. Share your purposes</p> <p>3. Invite them to join you as a partner in sorting out the situation together.</p>
Step four: Explore their story and Yours
<p>Listen to understand their perspective on what happened. Ask questions. Challenge the feelings behind the arguments and accusations. Paraphrase to see if you're got it. Try to unravel how the two of you got to this place.</p> <p>Share your viewpoint – your past experiences, intentions and feelings</p> <p>Reframe, reframe, reframe to keep on track. From truth to perceptions, blame to contributions, accusations to feelings and so on</p>
Step five: Problem-solving
<p>Invent options that meet each sides most important concerns and interests</p> <p>Look to standards for what should happen. Relationships that go on way rarely last.</p> <p>Talk about how to keep communication open as you go forwards.</p>

Appendix L: Study 2 – Participant information sheet

PARTICIPANT INFORMATION

The purpose of this information sheet is to provide you with sufficient information so that you can then give your informed consent. It is thus very important that you read this document carefully, and raise any issues that you do not understand with the investigator.

Name of Researcher: Frances Dodd

Name of Supervisor: Neill Thompson

Project Title: Addressing the influence of dominant leaders upon employees

1. What is the purpose of the project?

This research project aims to examine the influence of dominant, yet successful leaders upon individuals within the reality and complexities of the National Health Service (NHS). Leadership will be discussed as a complex process, so rather than looking just at leaders; the context of the behaviour, as well as their followers will also be examined. Previously the researcher has conducted interviews, and this workshop intervention was developed to address how the Individual can successfully manage the dominant leader in their daily work.

2. Why have I been selected to take part and what are the exclusion criteria?

You have been selected as part of a group who were emailed about the opportunity from the head of the department. The team also recently took part in the 360 leadership development and coaching programme, where this issue of dominant leaders became apparent.

3. What will I have to do?

You will be asked to complete three questionnaires before the workshop and then another one afterwards. The last questionnaire will be given to you in the follow up training in approximately 2 months. If there are any questions which you do not wish to answer you do not have to do so. The questionnaires should only take about 5 to 10 minutes to complete.

4. Will my participation involve any physical discomfort? You will not experience any physical discomfort as a result of participation in the study. However, if you do feel uncomfortable then you may take a comfort break at any time in the workshop.

5. Will my participation involve any psychological discomfort or embarrassment?

No psychological discomfort or embarrassment is expected as a result of being a participant in this study. If you do become uncomfortable or upset during participation then you may decline to answer any question, or withdraw from the study completely. During participation you may also take comfort breaks or stop participation completely. If after participation you begin to feel uncomfortable with the use of your data you may also withdraw by emailing the researcher within one month of participation.

6. Will I have to provide any bodily samples (i.e. blood, saliva)?

No, bodily samples will be taken as part of participation in the study

7. How will confidentiality be assured and who will have access to the information that I provide?

Upon signing a consent form you will be provided with a participant number which will be the only identifier for your data after this point. Consent forms and data will be stored separately not to allow identification of participant's data. During data transcription any names of people or places will be removed or replaced with pseudonyms. At the start of the questionnaire, you will be asked about your job role, although this will be kept anonymous. Once the project has been completed all documentation will be handed into Northumbria University stored securely and then destroyed.

8. Will I receive any financial rewards / travel expenses for taking part?

No monetary or other reward or compensation will be given as part of participation in the study.

9. How can I withdraw from the project?

You can withdraw from the project before participation and if you agree to participate, you may still withdraw during the interview by telling the Researcher. If you wish to withdraw from the project after participation you can email the researcher, within one month of participation and quote your participation number as given on the consent form: f.dodd@yorks.ac.uk. Or email the supervisor Neill Thompson; Neill.Thompson@northumbria.ac.uk. Upon withdrawal, all data help will be destroyed by the researcher, including in the consent form, audio and transcription.

10. If I require further information who should I contact and how?

If you require any further information on the project please email the researcher at; f.dodd@yorks.ac.uk. or the supervisor Neill Thompson; Neill.Thompson@northumbria.ac.uk. If you have any concerns about research please contact the Department of Psychology Ethics Chair (postgraduate) at andriy.myachykov@northumbria.ac.uk

If you have any concerns or worries concerning this research or if you wish to register a complaint, please direct it to the Department of Psychology Ethics Chair (Postgraduate) at the address below, or by Email: andriy.myachykov@northumbria.ac.uk

The data collected in this study will be used for a Occupational Psychology Professional Doctorate Thesis. It may also be published in scientific journals or presented at conferences. Information and data gathered during this research study will only be available to the research team named above, and the Postgraduate Ethics Chair (Andriy Myachykov). Should the research be presented or published in any form, all data will be anonymous (i.e. your personal information or data will not be identifiable).

All information and data gathered during this research will be stored in line with the Data Protection Act and will be destroyed 6 months following the conclusion of the study. If the research is published in a scientific journal it may be kept for longer before being destroyed. During that time the data may be used by members of the research team only for purposes appropriate to the research question, but at no point will your personal information or data be revealed. Insurance companies and employers will not be given any individual's information, samples, or test results, and nor will we allow access to the police, security services, social services, relatives or lawyers, unless forced to do so by the courts.

This study and its protocol have received full ethical approval from the Department of Psychology Ethics Committee (Postgraduate) in accordance with the School of Health and Life Sciences Ethics Committee. If you require confirmation of this please contact the Chair of this Committee, stating the title of the research project and the name of the researcher:

Dr Andriy Myachykov

Chair of Department of Psychology Ethics Committee (Postgraduate)

Northumbria University

Newcastle upon Tyne

NE1 8ST

UK

Appendix: M Study 2 – Participant Consent form

CONSENT FORM

Project title: Addressing the influence of dominant leaders upon employees

Principal Investigator: Frances Dodd

I confirm that my answers to the questionnaires will form part of overall group answer and that these group answers may be published in an appropriate journal/textbook or on an appropriate Northumbria University webpage. My name or other personal information will never be associated with the answers. I understand that I have the right to withdraw consent at any time prior to publication, but that once the information is in the public domain there may be no opportunity for the effective withdrawal of consent.

Tick or initial the box to indicate your consent to the above ☐

Signature of participant..... Date.....

Signature of researcher..... Date.....

Appendix N: Study 2 - Participant debrief form

PARTICIPANT DEBRIEF

Name of Researcher: Frances Dodd

Name of Supervisor: Neill Thompson

Project Title: Addressing the influence of dominant leaders upon employees

1. What was the purpose of the project?

This research project aims to examine the influence of dominant, yet successful leaders upon individuals within the reality and complexities of the National Health Service (NHS). Leadership will be discussed as a complex process, so rather than looking just at leaders; the context of the behaviour, as well as their followers will also be examined. Previously the researcher has conducted interviews, and this workshop intervention was developed to address how the Individual can successfully manage the dominant leader in their daily work.

2. How will I find out about the results?

If you have selected to receive results on the consent form then you will be emailed by the researcher upon completion of the project. A brief of the overall findings also formed part of the workshop today.

3. Have I been deceived in any way during the project?

You have not been deceived at any point during this study

4. If I change my mind and wish to withdraw the information I have provided, how do I do this?

If you wish to withdraw from the project you can email the researcher, within one month of participation and quote your participation number as given on the consent form: f.dodd@yorks.ac.uk. Or email the supervisor Neill Thompson; Neill.Thompson@northumbria.ac.uk. Upon withdrawal, all data held will be destroyed by the researcher, including in the consent form, audio and transcription.

If you have any concerns or worries concerning this research or if you wish to register a complaint, please direct it to the Department of Psychology Ethics Chair (Postgraduate) at the address below, or by Email: andriy.myachykov@northumbria.ac.uk

The data collected in this study may also be published in scientific journals or presented at conferences. Information and data gathered during this research study will only be available to the research team identified in the information sheet, and the Ethics Chair. Should the research be presented or published in any form, all data will be anonymous (i.e. your personal information or data will not be identifiable).

All information and data gathered during this research will be stored in line with the Data Protection Act and will be destroyed 6 months following the conclusion of the study. If the research is published in a scientific journal it may be kept for longer before being destroyed. During that time the data may be used by members of the research team only for purposes appropriate to the research question, but at no point will your personal information or data be revealed. Insurance companies and employers will not be given any individual's information, samples, or test results, and nor will we allow access to the police, security services, social services, relatives or lawyers, unless forced to do so by the courts.

This study and its protocol have received full ethical approval from the Department of Psychology Ethics Committee in accordance with the School of Health and Life Sciences Ethics Committee. If you require confirmation of this please contact the Chair of this Committee, stating the title of the research project and the name of the researcher:

Appendix O: Post workshop feedback

Follow up questionnaires – asked how you have applied the training and what was the outcome?

Out of the 33 follow up questionnaires, 85% of participants had initiated a challenging conversation. The circumstances of these conversations ranged from being with members of their team, to patients and students on clinical placements.

In relation to incivility behaviours, one participant commented how they had responded to negative feedback directed at them, and another discussed challenging a staff nurse, so cited a more senior member of staff.

Most comments focused on increased confidence with examples such as,

“more confidence in the knowledge and preparation for tackling a difficult situation”

“Learning to have conversations that I don’t want to have has been useful”

“Responded to some negative feedback directed at me. Challenged inappropriate behaviour with a member of staff, with positive outcome”

“more assertive in challenging behaviours”

“Had a conversation the week after the course – all the problems melted away during the conversation. No issues have arisen since”

“Spoke to a member of staff re punctuality. Staff member normally very defensive but when using learning shown in previous session, person agreed and behaviour changed”

“I have had a number of challenging conversations and two in particular where related to performance – I thought they both went well actually! One of them told me how he appreciated my input, and thanked me for being able to have a “2-way conversation” and not talking at him – the other felt comfortable enough to open up about mental health issues he had not previously talked about”

Out of all the qualitative comments only two participants mentioned negative aspects of having the challenging conversations, as below,

“I felt more confident, more prepared and more willing to have the conversation. The outcome of the conversation was not as positive as I’d hoped”

“Yes, positive outcome initially but after a few weeks evidence of unprofessional behaviours again”

Discussion in facilitated session in post workshop - when discussed in a facilitated session there were many examples of uncivil situations where the individuals had initiated a challenging conversation. Examples included, responding to negative non-verbal body language, or when another member of staff had belittled the profession, as well as unprofessional behaviour of staff.

Many also mentioned how having the technique and structured approach gave them the confidence to actually initiate a conversation, as well as saying it gave them confidence to stand up for themselves.

The second question asked how the participants had used the workshop.

The answers were around a few key areas, with the majority commenting on how they had learnt a new skill, such as,

“Very useful. Changed my attitude”

“I’ve found it really insightful”

“Feel better equipped how to structure/address a difficult/challenging conversation when it presents”

“Much more useful than thought it would be. Increased confidence to challenge others”

A few commented that it gave them reassurance, with comments such as,

“It was great...gives me reassurance that I’m doing ok”

“great opportunity to reflect”

Only one person commented on further training,

“The training is very useful though this is a skill in which I feel not very confident in doing. I feel that I need further training and due to personality struggle with this”

Appendix P: Study 2 survey

PRE-WORKSHOP QUESTIONNAIRE

Linking code

Code

So that we can link your surveys before and after training, please enter the day of the month that you were born, followed by the last 4 digits of your telephone number.

E.g. if you were born on 18th May and your phone number is 07789 254621, your code would be: 18 - 4621

Code: ____ ____ - ____ ____ ____ ____

(day of birth) *(last 4 digits of phone no.)*

Please use the same code on your pre-training/post and follow up questionnaire

PART 1 – Demographic data

The following questions provide demographic data for everyone undertaking the workshop. Please circle the answer that describes you:

Age

18 - 25

26 - 35

36 - 45

46 - 55

56 - 65

Gender

Female

Male

I'd rather not answer

Occupation

Physiotherapist

Occupational Therapist

Nurse

Other.....

PART 2 – Challenging communication Self-Efficacy

A difficult or challenging conversation involves managing emotions and information in a sensitive way, whilst also addressing issues such as poor performance or behaviour, discussing personal issues or dealing with personality clashes.

This questionnaire is designed to help us gain better understanding of the kinds of things that create difficulties for you in having challenging conversations.

Please rate how certain you are that you can do the things discussed below by writing the appropriate number. Your answers will be kept strictly confidential and will not be identified by name.

Rate your degree of confidence by recording a number from 0 to 10 using the scale given below:

0	1	2	3	4	5	6	7	8	9	10
Cannot do at all			moderately - can do				highly - certain can do			

We will ask you to rate your confidence to conduct a challenging conversation with a range of different groups

1. How confident are you that you have the skills and knowledge to have a challenging conversation?
2. How confident are you having a challenging conversation with a patient?
3. How confident are you having a challenging conversation with someone who is a lower grade than yourself?
4. How confident are you having a challenging conversation with a peer?
5. How confident are you having a challenging conversation with someone from another profession?

6. How confident are you having a challenging conversation with someone who is a consultant?
7. How confident are you having a challenging conversation with someone who is a higher grade than yourself?

Using the above scale -

How confident are you that you have the skills and knowledge to have a challenging conversation with each of the groups below

		When the unreasonable behaviour is directed at you (0-10)	When the unreasonable behaviour is directed at one of your team (0-10)
Patient			
Lower grade			
Peer			
Other profession			
Consultant			
Senior			

PART 3 – Resilience questionnaire – please score on a scale of 1 to 7 as to how much you agree or disagree with the statement.

Disagree

Agree

1. When I make plans I follow through with them.

1 2 3 4 5 6 7

2. I usually manage one way or another.

1 2 3 4 5 6 7

3. I am able to depend on myself more than anyone else.

1 2 3 4 5 6 7

4. Keeping interested in things is important to me.

1 2 3 4 5 6 7

5. I can be on my own if I have to.

1 2 3 4 5 6 7

6. I feel proud that I have accomplished things in my life.

1 2 3 4 5 6 7

7. I usually take things in my stride.

1 2 3 4 5 6 7

8. I am friends with myself.

1 2 3 4 5 6 7

9. I feel that I can handle many things at a time.

1 2 3 4 5 6 7

10. I am determined.

1 2 3 4 5 6 7

11. I seldom wonder what the point of it all is.

1 2 3 4 5 6 7

12. I take things one day at a time.

1 2 3 4 5 6 7

13. I can get through difficult times because I've experienced difficulty before.

1 2 3 4 5 6 7

14. I have self-discipline.

1 2 3 4 5 6 7

15. I keep interested in things.

1 2 3 4 5 6 7

16. I can usually find something to laugh about.

1 2 3 4 5 6 7

17. My belief in myself gets me through hard times.

1 2 3 4 5 6 7

18. In an emergency, I'm somebody people generally can rely on.

1 2 3 4 5 6 7

19. I can usually look at a situation in a number of ways.

1 2 3 4 5 6 7

20. Sometimes I make myself do things whether I want to or not.

1 2 3 4 5 6 7

21. My life has meaning.

1 2 3 4 5 6 7

22. I do not dwell on things that I can't do anything about.

1 2 3 4 5 6 7

23. When I am in a difficult situation, I can usually find my way out of it.

1 2 3 4 5 6 7

24. I have enough energy to do what I have to do.

1 2 3 4 5 6 7

25. It's okay if there are people who don't like me.

1 2 3 4 5 6 7

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